TAKING CARE OF HEROES: A CULTURAL STUDY OF HEALTH POLICY FORMATION

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ABSTRACT

This dissertation examines the formation of health policy as a cultural process in a large federal bureaucracy in the United States, namely the Department of Veterans Affairs (VA). The everyday experience of bureaucrats working in the VA is used to answer the question: why does the VA fail to meet veterans' needs in the face of a sacred trust, available political will, and robust resources? To answer the question, this project employs ethnographic methods that draw on participant observation at the headquarters office of the VA in Washington DC, archival research, and interviews with current and former VA employees during the Obama administration. I argue that care of veterans during post-war periods are critical moments of intervention that not only improved the population health of veterans but also impacted the ways in which America conceives and responds to health challenges. I also argue that when the VA operates at its best, it is often the leading edge of health reform, setting new standards for care and effectively establishing alternative models of care. Finally, my findings show that institutional factors play an important role in the process of health policy formation in ways that contribute to new understanding about causal conceptions of health. I conclude with a framework that draws on the lessons the VA affords, for health reform and advancing just health for all.

This is dedicated to my parents, Ayalew and Tsedale.

And to my husband Zeresenay, and my children

Lukas, Menna, and Gabriella.

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CHAPTER 1

INTRODUCTION: THE STRUCTURE OF HEALTH

This study examines how a large federal bureaucracy in the United States, the Department of Veterans Affairs (VA), makes health policy about and for veterans – in other words – how the VA takes care of heroes. I studied the everyday experience of bureaucrats working in the Office of the Secretary of the VA along with the documents they produced and the laws they enacted to trace how claims about veterans and their health are formed, reformed, challenged, and made authoritative. The role that institutional and discursive forces play in this process are empirical foci for this study. I demonstrate that health policy is an interactional achievement produced by those in power, their institutional context, and the discourses they produce. Studying how health policy is made at the multiple levels of government, including the cabinet-level, is a rare opportunity to "study up" (Nader 1974[1969]) gradients of power and, more specifically, better understand how powerful bureaucracies and those in power operate to shape and constrain the outcomes of health policy for veterans

The overall aim of this dissertation is to study the production of health policy as a cultural process. The VA is an ideal place to explore this issue because of its unique institutional culture and history that is tied to the birth of the nation's first federal policies concerning health for American citizens, namely veterans. This rich legacy provides a foundation to study the cultural and historical processes out of which health policy about veterans is made. More specifically, I examine the formation of the VA after the Civil

War and its subsequent development to the present within the specific historical contexts in which meeting the needs of veterans becomes a national priority. The fact that the VA often fails to meet veterans' needs, despite the priority placed on its sole mandate to care, also suggests there is a disconnect between the rhetoric of veterans' health policy and the ways in which health policy is practiced at the VA. By providing a detailed account of what bureaucrats in the VA do every day, I hope to better understand why the practice of making health policy sometimes lends to the VA's failure to meet veterans' needs.

Highlighting the role bureaucrats and their institutions play in producing the health problems veterans face reframes the source of veterans health problems from their individual behaviors to the structures responsible for fixing them. By shifting the context for the study of health policies to institutions this proposal makes an important contribution in the field of population health where the targets of reform have often been the behaviors, choices, and values of individuals (Holmes 2013; Quesada, Hart, Bourgois 2011). Furthermore, this shift also presents an opportunity to rethink accountability. The VA represents a different kind of social and political possibility for the structure of accountability by virtue of the fact that the responsibility for health outcomes of veterans lies with the state. This accountability for care is in part instituted through the legal and administrative powers of the state and its constitutive discourses. Thus studying the implementation of new ideas and programs as they are conceived in the institution and observing the ways in which they are translated from meetings into laws helps us to better understand how accountability for health is imagined and practiced.

This study is informed by three broad literatures: (a) the political and moral economy of health (b) the anthropology of bureaucracy and governmentality; and (c) the

anthropology of mass media. I will review each of these literature and discuss the contributions this study makes to each.

The Political and Moral Economy of Health

This study began when America was in the throes of an intense debate about healthcare reform ushered in by the administration of President Barack Obama. The eventual passage of the *Patient Protection and Affordable Care Act*, also referred to as the ACA or Obamacare, was historic and represented the most important reform in U.S. health policy since the establishment of Medicaid and Medicare in 1965. The heated debates, controversies, and maelstrom of commentary that led up to the passage of this historic piece of legislation and continued through its implementation lay bare fundamentally *political* disagreements about the appropriate role of government and the limits to which federal government *can* do the work of care. In other words, the battle for health reform instructs that health policy is politics by other means.[1]

On veterans' health issues, questions of virtue and justice are too obvious to deny. The sacrifices veterans make in service to their country are universally recognized as debts that must be repaid. Considerations about how these debts are to be repaid, in what amounts, and what duties are owed to returning warriors are part and parcel of the everyday work at the VA. Deciding what veterans deserve is fundamentally about justice: "Thinking about justice seems inescapably to engage us in thinking about the best way to live" (Sandel 2009:10). Examining the conditions under which people live is the main

[1] "Health is politics by other means." Nelson, Alondra. 2011. *Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination*. Minneapolis: University of Minnesota. p.ix

purview of public health. Justice and public health collide when exploring issues of veterans' health policy and the result poses one main question: why does the U.S. consistently fall short of meeting its commitment to veterans in the face of a sacred trust? This study seeks to answer this question.

Caring for veterans is a compelling context to better understand how and why government can fail those it is intended to serve. Understanding how failure happens, in the most ideal of circumstances, when political will and resources are aligned, can shed light on underexplored impediments to achieving just health policy. In this dissertation I explore the practical underpinning of the quest to attain "just health" (Daniels, 2008) for veterans and its relevance for just health policy for all Americans. In *Just Health: Meeting Health Needs Fairly* the bioethicist Daniels presents "an integrated theory of justice and population health," that uses John Rawl's theory of "justice as fairness" and argues that "a theory of justice and health must tell us what we owe each other in the protection and promotion of health" (Daniels 2008:1). This argument is predicated on the belief that "health is of special moral importance because it contributes to the range of exercisable or effective opportunities open to us" (Daniels 2008:2). I also describe how this quest for just health policy is informed by a unique aspect of the bureaucracy at the VA – its moral economy. The moral economy of the VA is its greatest organizational asset and it derives its strength from the sense of mission VA employees bring to their work. This mission is driven by the substance of the work which was described by one VA employee as "rebuilding people after they have been broken."[2] I argue that this organizational environment makes the VA a preeminent site to consider the challenges of

[2] Staff interview #20, March 25, 2016.

just health policy and what this means for strengthening the moral vision of government which I define as "taking care of people".

Taking care of sick people has long been the purview of health care and medical anthropologists have long examined the delivery of health care globally. A prominent theme in this deep and vast literature is a focus on structural factors that shape and create inequities in access to care and disparities in health outcomes or what has been referred to as the political economy of health perspective (Baer et al. 2013[1997]; Navarro 1976, 2002; Rylko-Bauer and Farmer 2002, Salmon 1990; Singer 2000). This theme informs the theoretical perspective known as critical medical anthropology (CMA) (Baer, Singer, and Susser 2013 [1997]) which emphasizes "the importance of political and economic forces, including the exercise of power, in shaping health, disease illness experience, and health care" (Singer and Baer 1995:5). Central to the CMA perspective is the recognition of health as a profoundly political issue and the role power plays as a "fundamental variable in health-related research, policy and programming" (Castro and Singer 2004: xiv).

Kleinman, Das, and Lock built on this observation and coined the term "social suffering" to describe the suffering power causes (1997). "Social suffering", they write, "results from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems" (Kleinman, Das, Lock 1997: ix). In other words, "social institutions, such as health-care bureaucracies, that are developed to respond to suffering can make suffering worse" (Kleinman 2010: 1519). Kleiman goes on to cite the VA and its failure in treating psychiatric trauma among returning veterans from Iraq and Afghanistan as an example of

social suffering caused by institutions (2010). Farmer expanded the concept of social suffering to include "structural violence" (1990, 1996, 2001, 2003, 2004), a term he uses to re-interpret theorizations of power and agency. He borrowed this term from sociologist Johan Galtung (1969)[3] and describes the concept of structural violence as being: "'structured' by historically given (and often economically driven) processes and forces that conspire – whether through routine, ritual, or as is more commonly the case, the hard surfaces of life – to constrain agency" and thereby determine who lives and dies (Farmer, 2003: 40).

The central question an "anthropology of structural violence" (Farmer 2001) poses is: How do social forces get under the skin? "By what mechanisms do social forces ranging from poverty to racism become *embodied* as individual experience?" (Farmer 1996: 261-262). Farmer's draws on Johan Galtung, liberation theology, Bourdieu, and Foucault to theorize power and its effects on structuring the unequal life chances of the world's poor. In his formulation "pathologies of power" both constitute a sickness and cause sickness (2003). This creative framework is a unique contribution to scholarship about power. Structural violence is the centerpiece of Farmer's conceptualization of power and his primary justification for why access to health care is a fundamental human right. Critics of the literature on structural violence as it relates to health have argued broadly that recognizing history or adding race and gender "does not solve the problem" (Bourgois and Scheper-Hughes 2001: 318). These critics also argue that structural violence as a concept is too broad and operates as a black box (Bourgois and Scheper-

[3] Galtung defined structural violence as "the indirect violence built into repressive social orders creating enormous differences between potential and actual human self-realization" (1975:173).

Hughes 2001). Despite these critiques, what an anthropology of structural violence teaches us is that health is socially, politically, economically, and historically determined and is not the product of individual behavior alone.

Moving understanding about health outcomes beyond individuals is the purview of another vast and broad interdisciplinary literature about the social determinants of health. This literature goes way beyond medical anthropology and spans public health, sociology, and medicine (Diez Roux 2007; Galea, Hall, and Kaplan 2009; Kawachi and Kennedy 1999; Knapp and Hall 2018; Marmot 2006; Rhodes 2002). This literature developed in response to critiques of individual risk that exclusively locate health outcomes in the behaviors, choices, and values of individuals (Holmes 2013). Similar to structural violence, this literature is primarily concerned with how socio-cultural forces influence biological outcomes (Boas 1912; Douglass 1950; DuBois 1906; Farmer 1990,1996, 2001; Fullwiley 2011; Goodman 2006; Gravelee 2005, 2009; Lock and Kaufert 2001; Krieger 2001, 2005; Marmot and Wilkinson 2006; Montoya 2011; Morgan 2009; Rapp 1999; Virchow 1848). In this literature, the "fundamental causes" of health (Phelan and Link 1995) are material mechanisms and/or psychosocial mechanisms that influence health in modifiable ways, as shown in Figure 1.[4] Missing from these competing causal conceptions of health are institutional mechanisms that contribute to health policy formation.

[4] Figure 1 is adapted from Bravemen and Egerter 2008.

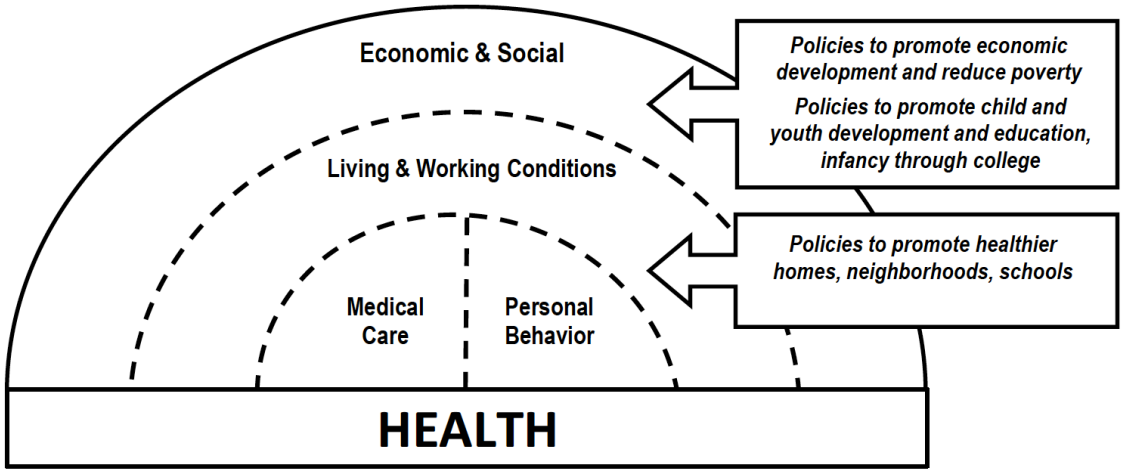

Figure 1, The Modifiable Factors That Influence Health

More specifically, the practice of making health policy in its everyday context by bureaucrats and its resulting effects on shaping health policy outcomes has not been explored as a social determinant of health outcomes. Yet, institutional decision-making processes could play an important middle ground in understanding fundamental causes of health outcomes (Phelan and Link 1995). This study will contribute to this gap in knowledge by studying the ways in which making health policy is practiced at the VA. As part of my analysis, I followed the social life of decision-making in the VA by tracing negotiations, disagreements, and struggles bureaucrats have about health policies and how these contestations are managed. I also paid special attention to how bureaucrats navigate the institutional apparatus of the VA and what this means for how ideas about health policy are taken up or foreclosed.

The absence of health policy formation as a mechanism in both the literature on structural violence and the social determinants of health is a gap this dissertation will fill. I argue that studying the ways health policy is formed in the VA can help unpack the

black box of structural violence by ethnographically revealing the institutional mechanisms that may contribute to new causal conceptions of health. In particular, the structuring effects of the VA on both the practice of health care and the policies that shape it is a powerful example of what Wolf has described as "structuring power". This kind of power is "manifest in relationships that not only operates within settings and domains but also organizes and orchestrates the settings themselves, and that specifies the direction" of actions and outcomes (Wolf 1999: 5). Structural power makes "some behaviors possible while others are impossible or even unthinkable" (Wolf in Kingfisher and Maskovsky 2008: 7)

Studying the process and effects of VA's structuring power on health policy formation presents the opportunity to examine ways in which institutions that assume responsibility for health may become "structurally nonviolent". This makes a critical intervention in the above literature which assumes that structure is invariably harmful on health outcomes and opens up the possibility that "regimes of care" (Ticktin 2011:3) can do no harm. Studying the context of health policy-making itself as an element of structure that impacts the health outcomes of veterans also contributes to an emerging literature on the "anthropology of health reform" (Dao and Mulligan 2016) .

Studying Up the State: The Anthropology of Policy and Governmentality

Forty-five years ago, in her article "Up the Anthropologist", Laura Nader called on anthropologists to study "up" gradients of power (1974[1969]). In this seminal work, she discusses the consequences of not studying up – namely its effects on limiting the theories social scientists develop and the limited view of science it gives us. To make her

case, she gives an example that shows how addressing this empirical void would change the ways we think about the problems affecting poor communities. More specifically, she demonstrates the extent to which exclusion of the powerless from legal, municipal, and police services is brought into sharp relief when the focus shifts to the powerful. Similarly, this study builds on this approach by reconstructing the ways in which problems affecting veterans' population health in the United States are understood when the focus is on high-ranking members of the VA charged with researching, writing, and implementing new health care policies of veterans.

Widening the anthropological lens to include a sharp focus on the powerful has been a productive development. A key contribution of this approach has been the examination of modern institutions and bureaucracies that hitherto had been excluded from the anthropological literature (Brenneis 1994; Ferguson 1990; Handelman 1981; Herzfeld 1992; Lazarus-Black 2007; Schwartzmann 1993; Strathern 2000). Within this larger literature, there is a dearth of studies about "the main occupation of contemporary states: administration, regulation, delegation" (Bernstein and Mertz 2011). The proposed study will contribute to this gap in knowledge by examining the administrative and legal powers of the VA in its everyday life of taking care of veterans.

This institutional context also provides an opportunity to make a contribution the literature on the structural determinants of health. The VA is America's largest health bureaucracy and as such provides an opportunity to encounter the administration of health care at a level that is too often under explored in debates about health care - namely at its structural core. Similarly, structure in the traditional ways it is theorized in the anthropological literature leaves out the organizational environment (Bourgois 2008;

Farmer 2008; Holmes 2013). Yet, the organizational environment of a bureaucracy like the VA's constrains and directs the possible outcomes for health policy formation in ways that foregrounds "organizational power" which has been described as "the ability to shape instrumentally the environment or settings where others act" (Kingfisher and Maskovsky 2008: 7). I explore the relationship between organizational power and structural power in the context of the VA and what this means for health policy formation. The VA's power lies in its capacity to structure health care delivery, both in its practice and by constituting the policies that shape it.

Since the VA's health bureaucracy is a microcosm of the U.S. health care industry, better understanding the conditions under which health policy decisions are made at the VA provides a window into the inner workings of how health bureaucracies more generally structure outcomes. Understanding the institutional realities of bureaucracies making decisions about health care policy is part of a larger literature in the anthropology of bureaucracy. Bureaucracies are powerful and have been described by anthropologists as the "preeminent technology of power in the contemporary world" (Heyman 1995: 262). But this same literature also refers to them as incredibly dysfunctional, inefficient organizations that have been characterized as indifferent and incompetent when it comes to servicing people (Herzfeld 1992; Graeber 2015, 2012). This context of powerful dysfunction makes the study of bureaucracies a productive departure point to re-think power. We tend to think of power as being complete and efficient in its effects. But the study of bureaucracies complicates this picture. If bureaucracies are so powerful, why is it that so often they fail?

This question is particularly vexing in the VA because its legitimacy relies entirely on improving the care of veterans. Anthropologists that have examined similar questions go as far as to say bureaucratic responses to suffering often make the problem worse (Kleinman, Das, and Lock 1997). Other anthropologists have said that a focus on the failure of bureaucracies is misplaced and that the real importance lies in the "side effects…effects that are at one and the same time instruments of what 'turns out' to be an exercise of power" (Ferguson 1990: 255). Ferguson's observations about the development apparatus and the ways in which it served to expand bureaucratic state power and depoliticize poverty is what he calls the "anti-politics machine" (1990). This machine served to sanitize and cloak the expansion of state power in Lesotho under the guise of development and its technocratic mission. Ferguson's "anti-politics machine" is a potent mechanism to conceal the operation of power. It is what Foucault describes as a "political technology" which works to conceal its own operation (Dreyfus and Rabinow 1982). Dreyfus and Rabinow further explain this idea: "political technologies advance by taking what is essentially a political problem, removing it from the realm of political discourse, and recasting it in the neutral language of science" (1982: 196). In the case of the "anti-politics machine", the technocratic discourse of development is analogous to the language of science and medicine that dominate health care policy. Similarly, health policies can operate as political technologies that obscure power through their use of expert knowledge as a form of legitimacy (Mosse 2011) and guise of neutrality. Bureaucracies can further diffuse these processes and make it more difficult to locate power by displacing it.

Expert knowledge plays a particularly prominent role in shaping policy at the VA in the form of "thought-work"(Heyman 1995, 2004). Heyman defines "bureaucratic thought-work" as "the routine production of thoughts about and consequent actions aimed at the control of the slippery, sometimes resistant, recipients of organizational orders" (Heyman 1995: 261). The idea that bureaucracies think has older roots that date back to Weber's characterization of a rational bureaucracy with "rules, means-ends calculus, and matter-of-factness" (Weber 2006: 70). According to Weber, there are certain forces that led to increased bureaucratization, such as, systems of taxation, police protections, and welfare policies which all require increasing amounts of administration. Weber goes on to emphasize the technical efficiency of bureaucracies as their quintessential strength.

Lipsky's work on bureaucracies and focus on "street-level bureaucrats" emphasizes the role that both play in delivering government services to everyday people: "Most citizens encounter government (if they encounter it at all) not through letters to congressmen or by attendance at school board meetings but through their teachers and their children's teachers and through the policeman on the corner or in the patrol car. Each encounter of this kind represents an instance of policy delivery" (Lipsky 1980: 3). An important element in Lipsky's description is the role that bureaucrats' discretion plays in producing the effects of bureaucracies. Street level bureaucrats selectively apply rules largely because there is room to interpret and use discretion. This discretion leaves them vulnerable to indifference. Herzfeld describes the "indifference" of bureaucracies and attributes it to the ways in which bureaucracies reduce people into categories and in so doing exclude them from norms of hospitality (1992: 19-20). In the context of the VA,

the level of discretion bureaucrats have to deny or grant claims imbues them with a great deal of power over the distribution of resources. This demonstrates what Weber has called the "power position of bureaucracy" (2006: 63). This power is magnified when one consider the numerous ways in which bureaucracies control the outcomes of people's lives. The VA is a context that dramatically illustrates the ways in which bureaucracies not only shape life outcomes but also determine who lives and who dies. Thus there is a force with which bureaucracies act that makes them an ideal context to consider theories about power. Despite this power, as Gramsci understood, bureaucracies are far from efficient.

> The bureaucracy is the most dangerously hidebound and conservative force; if it ends up by constituting a compact body, which stands on its own and feels itself independent of the mass of members, the party ends up by becoming anachronistic and at moments of acute crisis it is voided of its social content and left as thought suspended in mid-air (Forgacs 2000: 219).

The resistance to change that bureaucracies often exemplify can be viewed as a window into the ways in which power positions are produced and sustained. If change is failed reproduction, then failed change is successful reproduction. What is it about bureaucracies that make them a potent mechanism for the reproduction of power? Answering this question builds on a literature in the anthropology of policy. The main question an "anthropology of policy" poses is: "how do policies 'work' as instruments of governance, and why do they sometimes fail to function as intended?" (Shore and Wright 1997: 3). Policy is an instrument of power and studying the ways in which policies are formed, contested, and implemented inside the state reveals/traces the formation of myriad forms of power in contemporary society. Similar to the relationship between

policy and power, policies are instruments through which governments and bureaucracies enact power. As Shore and Wright note: "To adapt a metaphor from Arthur Koestler (1967), policy is the ghost in the machine – the force which breathes life and purpose into the machinery of government and animates the otherwise dead hand of bureaucracy" (1997: 5).

Policies are the ways in which government manifests its effects. Foucault's work on the "art of government" traces the history of the formation of the state as a new form of political power that changes the relationship between the state and the individual. "The art of government…is concerned with…how to introduce economy, that is the correct manner of managing individuals, goods and wealth within the family, …how to introduce this meticulous attention of the father towards his family, into the management of the state" (Foucault 1978: 208, quoted in Rabinow 1984: 15). This "art of government" broadened the scope of the political field to include all matters of social life. Foucault's concept of governmentality grows out of these observations and extends his discussions of power by linking the constitution of subjects to the formation of the state. He uses this concept to discuss the ways in which government's widened scope in modern times has shaped and regulated people's conduct. More specifically, he describes governmentality as "the conduct of conduct":

> …studying the techniques and procedures by which one sets about conducting the conduct of others. That is to say…to pose the question of norms of behavior first of all in terms of power, and of power that one

> exercises, and to analyze this power as a field of procedures of government (Foucault 2010: loc 448)[5].

This concept links politics to norms. Other scholars have demonstrated that governmentality is best understood as an intellectual apparatus "for rendering reality thinkable in such a way that it is amenable to political programming" (Rose, 1996: 42). Rose and Miller build on this further and take Foucault's concept of governmentality and divide it into two distinct aspects: rationalities ("thought") and technologies ("interventions") (2013). Rationalities refer to "styles of thinking, ways of rendering reality thinkable in such a way that it was amenable to calculation and programming" (Rose and Miller, 2013[2008]: loc 449). Technologies refer to "all those devices, tools, techniques, personnel, materials and apparatuses that enabled authorities to imagine and act upon the conduct of persons individually and collectively, and in locales that were often very distant" (Rose and Miller, 2013[2008]: loc 448). I use Miller and Rose's framework for studying governmentality to analyze the ways in which the VA conceived of veterans' health problems and the role expert knowledge played in health policy formation. I explore the rationalities and technologies that the VA uses to govern the health of veterans and examine the ways in which these technologies both subverted and maintained the status quo as it relates to health policy for veterans. This makes a contribution to the literature on governmentality that traditionally has positioned the use of expert knowledge in policy formation as a mechanism to consolidate the legitimacy of an existing social order (Shore, Wright, Pero 2011).

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[5] "Loc" refers to an electronic location/position in a Kindle version of a book. Older electronic books only have electronic locations while newer version have both page numbers and electronic locations.

Media, Representation, and the State

The literature on the anthropology of mass media includes various legacies within anthropology and media studies, including the fields of visual anthropology, cinema studies, visual communications, and indigenous media (Ginsburg 2005). Thus its study necessarily explores processes of media consumption, production, and circulation. There are numerous approaches to the anthropological examination of media, which include studying media as an institution, as a set of communicative practices, as cultural products, or as social activities (Spitulnik, 1993). For the purposes of this dissertation I will situate media as a social practice. Within this literature, an important theme is the relationship between media and power.

The power of media lies in the ways in which it is used to construct/reflect reality as truth and the impacts these representations have on shaping contemporary society. Media is a battleground for the politics of representation because it is a powerful vehicle to naturalize representations. Who we see and who we don't see represented in the "media worlds" (Ginsburg, Abu-Lughod, and Larkin 2002) around us defines, in some ways, who counts. These meanings circulate visually and reflect, to varying degrees, power relations with important resultant effects.

The state has long been interested in populating the public sphere with representations that serve its interests. In *Dramas of Nationhood,* Abu-Lughod shows how media, more specifically television, "is a key institution for the production of national culture in Egypt and national identity" (2005: 7). This is particularly true when state media is controlled by government, as is in the case of Egypt. Abu-Lughod argues that television disseminates story lines that have embedded moral messages intended to

shape subjectivities in a particular configuration of national citizenship and create what she calls a "national habitus" (2005:45). More specifically, she argues that TV serials in Egypt were creating new modes of subjectivity and new configurations of personhood that aligned with state interests.

Media mediates experience and contributes to the way we see ourselves. Media circulates and transmits ideas about how one should inhabit the world and becomes embedded in the social words of those who receive it. This circulation shapes ideas, habits, and tastes, and creates shared meaning. These processes lead to the production of individual and collective identities (Abu-Lughod 2005; Spitulnik 1997; Schiller 2018). Anderson's classic work on the way in which different media forms, from novels to newspapers, create a shared sense of belonging to an "imagined community" that is rooted in a collective identity is useful for theorizing the VA's use of media (1983). Anderson illustrates this idea in his observations about newspaper readers: "…the newspaper reader, observing the exact replicas of his own paper being consumed by his subway, barbershop, or residential neighbors, is continually reassured that the imagined world is visibly rooted in everyday life" (1983: 35-36).

Anderson goes on to explain how this creates "confidence of community in anonymity" and calls this the "hallmark of modern nations" (1983:36). An important construct for all of these works is Habermas's "public sphere" (1974). Habermas explains this concept in the following passage:

> By "the public sphere" we mean first of all a realm of our social life in which something approaching public opinion can be formed. Access guaranteed to all citizens. A portion of the public sphere comes into being

> in every conversation in which private individuals assemble to form a public body (1974: 49).

The public sphere is the site in which alternative narratives about identity are constructed. Spitulnik's work on the social circulation of radio discourse in Zambia showed this and make a larger argument about the ways in which engagement with mass media in the public sphere constructed community (1997). By examining phrases and discourse styles that are taken from radio messages, and following them as they get recycled in everyday usage, she shows how shared meaning is created through social circulation and the possible identities it creates.

Schiller's work on alternative media practices in Venezuela illustrates the use of media in creating counter-hegemonic narratives by exploring community media outlets in Venezuela that have used media to express an alternative perspective of Caracas's barrios (2018, 2011). More specifically, Schiller shows how political battles in contemporary Venezuela have increasingly been fought in the media and the ways in which grassroots video production in particular is being waged as a tool for social transformation. The origins of the local community media station she studied, Catia TV, "spring from the private media's biased portrayal of Caracas's poor neighborhoods" (Schiller 2011: 115). The founders of Catia "understood the media produced by and for their community not only as a way to valorize and re-present Caracas's barrios but also as part of an effort to organize for better living conditions" (Schiller 2011: 115).

In this study, I draw on these foundational examples of media shaping identity to contextualize the role that media plays in shaping the construction of the archetypal warrior identity of service members in popular culture and what this means for the work

of the VA. I contribute to the literature on the uses of media in crafting identity in the public sphere by exploring the VA's effort to populate the public sphere with a new archetype, the "vulnerable" warrior, and how this cultural struggle hinges on displacing earlier representations of the brave and invincible warrior that were produced by the Army. My findings about the VA's use of media builds on the scholarship of media and identity in interesting ways that raise questions about the ends to which state-media is used. For example: what does it mean for the state to construct narratives about warriors that may not serve its interests?

Anthropology, History, and the VA

The *Annals of Anthropological Practice* devoted an entire special issue to the VA entitled "Anthropology Goes Public in the VA" (Besterman-Dahan and Hamilton 2013). The seven articles in the special issue examine the broad nature of anthropological research being conducted in the VA which range from examining issues of dignity for spinal cord injury patients to exploring secure-messaging and new patient communication technologies. This wide spectrum is all categorized as health services research (HSR). HSR is a type of research that is defined as:

> a multidisciplinary field of scientific investigation that studies how social factors, financial systems, organizations structures and processes, health technologies, and personal behaviors affect access to health care, the quality and cost of health care and ultimately health and well-being (Lohr and Steinwachs 2002:15)

A defining characteristic of HSR is to go beyond disease frameworks to examine the strengths and weaknesses of health care delivery systems (NRC 2005). The VA has a robustly funded HSR program that is one research arm of four in the Office of Research

Development (ORD). The ORD program manages a $670 million budget.[6] The HSR program takes a particularly wide and comprehensive view of health care delivery (see Figure 2) because of its constituents who anthropologists have defined as "a vulnerable population" (Sobo 2013).

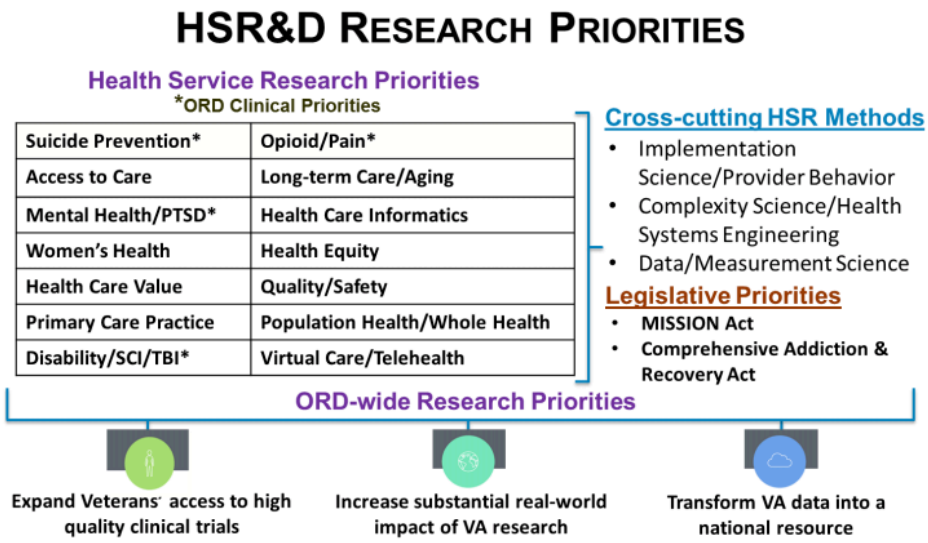

Figure 2, Overview Of VA HSR Priorities in 2018

Sobo has further pointed out that "within that broad group there are subsets of doubly vulnerable persons (substance using Veterans, women Veterans, Veterans who serve as chaplains, homeless Veterans, Veterans with PTSD" and so on (2015: 3).

It is in this context that anthropologists studying the delivery of health care have thrived. McCullough, Hahm, and Ono write, "what we have learned [in the VA] is how

[6] https://www.hsrd.research.va.gov/about/director.cfm. Accessed February 1, 2019.

critical anthropology is to HSR and how well positioned we are as anthropologists to do this work" (2013:17). Sobo further explains:

> As VA employees, anthropologists can make the kind of difference that most academically employed anthropologists only can dream of and that even practicing anthropologists who do contract work rarely get to enjoy. One key reason for this is that change at the VA, when fomented by an anthropologist who also is a VA employee, is change from the inside. The difference this makes is palpable, both in terms of practical outcomes and in the way it affects anthropology (2013:1).

Sobo's comments are largely about the potential to institutionalize change at the VA, and in particular change that improves the health care of Veterans since all of the anthropologists employed at the VA work within the Veterans Healthcare Administration (VHA).[7] Closser and Finley share similar observations and write, "anthropologists now have an unprecedented opportunity to contribute to the creation of clinical and public health structures more deeply informed by core anthropological concerns" (2016: 1). Sobo goes on to describe the work that anthropologists do at the VA as "generative" for the field of medical anthropology but I argue it goes further than medical anthropology given VA helps set the direction of care for health care generally for the United States (Closser and Finley 2016). These anthropological reflections about what the VA offers to anthropologists who work there share a common concern with change and changing bodies of knowledge. McCullough, Hahm, and Ono write, "Anthropology in VA is both the anthropology *of* medicine and public policy and anthropology *in* medicine and public policy" (McCollough, Hahn, and Ono 2013:17).

[7] There are about 60 anthropologists employed at VHA (VA 2014).

The research that anthropologists have conducted in the VA to a large extent has focused on the theme of social and institutional politics of pathology within the field of medical anthropology (Finley 2011, Hautzinger and Scandlyn 2013: Kilshaw 2008; Wool 2015; Young 1995). This work has focused on veterans bodies and the ways in which veterans' illnesses and bodies are understood and embedded in a set of ethical relationships with the state that deploys them (Messinger 2012). Other work has taken an implementation science perspective to better understand how interventions can improve the quality of care in the VA (Finley et al 2015; Sobo, Bowman, and Gifford 2008). My work is a departure from this body of work in that the object under anthropological examination is the institution not veterans' bodies. My study is also the first to be conducted on headquarters itself, examining it at its structural core.

There is a related literature in history that is relevant for my dissertation. The VA and American veterans are the subject of a vast historical literature (Glasson 1918; Kelly,1997; Logue 1992; Logue and Barton 2007; Skockpol 1992; Weber and Schmekebier 1934). Historians have studied every aspect of the institutional development of the VA, its political history and the ways in which it cares for veterans (Ortiz 2012). A prominent theme that is important for contextualizing my own work is the "problem" of the disabled soldier (Gerber 2000). Historians have traced the emergence of the category of the "disabled veteran" and the framing of this category as a "national problem" to the decades between the Civil War and World War II when medical advancements in treating wounds led to higher casualty survival rates (Gerber 2000). In these intervening decades, the disabled veteran was viewed as a threat to America's economic and social stability (Severo and Milford 1989).

A second theme in this literature that is relevant for my work is the ways in which entitlements and privileges afforded to veterans became a model for eventually expanding rights to other Americans. For example, scholars have shown the ways in which the VA's policies directed at the care of disabled veterans became the leading edge of the expansion of federal disability policy for other Americans (Jennings 2016). Similarly, Keene (2005) has shown the rights afforded to African American veterans served as an opening to the rights that the civil rights movement would eventually bestow on other African Americans. Lastly, other scholars have argued that the broad array of entitlements and programs afforded to American veterans have led to the overall expansion of government welfare activities (Kelly 1997; Longmore and Umansky 2001; Skocpol 1992). This literature suggests that veterans' benefits are an important site of federal policy development for all Americans – not just veterans.

A third and final theme in this literature that is important scaffolding for this study explores the centrality of veterans' issues to modern state formation. Veterans became the subject of countless federal social assistance programs that served as an engine for the creation of numerous bureaucracies and administrations that expanded the state (Kelly 1997; Scott, 2003[1993]). Historians have explored the cultural meaning of these social assistance programs and shown that "organizational and career interests" influence the forms and effects these programs take (Skocpol 1992: 41-42).

Methods and Challenges

This dissertation grew out of my theoretical frustration during my primary care medical residency with health interventions focused on individual behavior to the exclusion of profound data that pointed to structural factors. The lived experience of

being a primary care doctor in the South Bronx made it painfully clear that health services and interventions directed at individuals were insufficient for improving the health of a population. So when I finished my primary care residency, I "hit pause" to re-think my next steps and this dissertation is the result of that intellectual journey. I didn't know it then, but this was right before the country would finally decide to do something about the disarray and dysfunction that characterized our health care system. Though it is conventional knowledge that "the performance of the U.S. health care system ranks last compared to other high-income countries" (Schneider, Sarnak, Squires et al 2017: 6) while spending more on health care than other high-income countries; what is seldom discussed is what it means to *work* in the world's worst performing health care system? The answer is simple – it's "heartbreaking" as a VA doctor described during the VA scandal of 2014 in which the revelation of falsified patient waiting lists led to the resignation of the Secretary of the VA, Eric Shinseki.[8]

VA's history is replete with instances of scandal as I will show. But upon closer examination, the VA's problems are about the more general dysfunction of the health care system in the U.S. from the shortage of primary care doctors to the continuing financial crisis of cost in medical care. Therefore, studying the VA affords the chance to better understand what can be done to improve the delivery of health care in America. Though this study began with frustration, the process of actually doing the research has completely recovered my sense of hope that structural factors can be changed.

[8] Interview with Staff Member #22, February 3, 2017.

I began this study on a leave of absence from graduate school. Having been accepted into a PhD program in Anthropology, I was subsequently chosen to be a White House Fellow. The White House Fellowship is a prestigious leadership training program that provides professionals with experience in government service. President Barack Obama had just been elected and I was selected to be in the first class of Fellows in his administration. Prior to beginning my year, I went to the Chair of my department to discuss how best to use this experience. She gave me her support along with wise advice to "document everything". I then immersed myself in the life of a civil servant in the United States government and what would turn out to be a longitudinal study of the halls of power.

This study employs a combination of archival research, participant observation (Hammersley and Atkinson 1995), and informal interviews. These methods were supplemented by semi-structured, in-depth interviews with 26 senior VA officials that work or previously worked in multiple levels of the VA administration, including the Office of the Secretary of the VA. I accrued a large historical archive of meeting minutes, Power Points and other such documents that dated back to 2009 because of my access as a White House Fellow. I also spent three consecutive summers at the VA documenting and studying its history of administrative decision making. This archive is a rich empiric source I draw upon throughout this study.

The prime field site for observation in this study was the day-to-day activities of the strategy group in the Office of the Secretary. This site was chosen for two reasons. Firstly, site function. The strategy group made and executed all executive decisions about the operation of the VA. It is also the locus where problems that arise in lower levels of

the organization arrive to be fixed. As such, it provides a comprehensive window into the entire organization's operation. Secondly, no anthropological study of the VA had ever been conducted in the executive suite of the headquarters office, which is precisely at the level where the structuring power of the VA is most concentrated. Since an aim of this study was to encounter the structural determinants of health polity formation, gaining a window into the "organizational power" of the VA, in other words, its "ability to shape instrumentally the environment or settings where others act" (Kingfisher and Maskovsky 2008:7), was critical. From this site, the ethnographic research was conducted along the lines of "follow the people" and "follow" the documents in multi-sited fieldwork (Marcus 1998). My interviews included VA bureaucrats working in the Office of the Secretary and other levels of the administration. Data collection followed the activities of the bureaucrats in their work setting, including observing meetings related to making veterans' health policy that took place outside of the VA, and I collected the documents that were produced along the way. Power Point presentations and diagrams used in meetings to guide conversation were also important sources of data for this study. Characterizing the process by which ideas spoken in meetings are framed using documents, diagrams and presentations, in addition to describing the process by which these data are created, is part of what my research findings reveal.

Lastly, the methodological challenges of studying inside the state deserve special mention since power often evades study and I had direct access to it. The state is a form of power that can resist discovery. This is a central problem for studying the state that makes it difficult to access as an object of inquiry. As Abrams suggested many years ago:

> Any attempt to examine politically institutionalized power at close quarters is, in short, liable to bring to light the fact that an integral element of such power is the quite straightforward ability to withhold information, deny observation and dictate the terms of knowledge (1977:62).

My approach to overcoming this methodological challenge draws on Karen Ho's work studying and penetrating Wall Street. Ho became a Wall Street worker (2009). Her methods for "studying up" were based on what she calls "institutional kinship":

> To enable this research, I leveraged my socioeconomic background and connections with elite universities – the only sites from which Wall Street investment banks recruit and hire… My path to Wall Street was made possible by the institutional, elite "familial" connections between particular universities and Wall Street investment banks where alumni from prestigious universities have an inside-track into Wall Street (Ho 2009: loc 216).

Ho took a leave of absence from her graduate studies and accepted a job at a Wall Street investment bank. During this time, she "did not secretly conduct field work" (Ho 2009: 14). Instead, she kept a journal "in order to record the initial strangeness and surprises of the ethnographic encounter, the awakening into Wall Street life" (Ho 2009: 14). She also openly acknowledged to her colleagues that she was planning to return to study Wall Street to study its culture. Ho's methods of forthright transparency gained her impressive access to the inside workings of Wall Street. I relied on similar methods in my study of the state and found the most direct approach to studying power to be the most effective. Like Ho, I also relied on my institutional kinship and privileged connections to gain access as well as to secure a very competitive fellowship that allowed me to work at the VA. When I began working at the VA I kept a journal to document my own indoctrination into government service.

While there is a plethora of historical studies that examine the modern expansion of the federal government through the lens of veterans' policy, there is little about the VA in the anthropological literature. To date, there has been no ethnographic investigation of the VA at the federal level that explores its "regime of care" and the ways in which its everyday activities of surveillance, record-keeping, and forms of social assistance shape veterans' health policy outcomes. This study will fill this gap by using the literature in the anthropology of governmentality to examine how the VA governs the health of veterans.

Summary and Synopsis of Forthcoming chapters

In Chapter Two, I review the VA's history and provide the context for understanding how war gave birth to the imperative to care for veterans. In this chapter, I pay close attention to post-war periods in VA's history as being critical periods of intervention that changed the ways in which care was delivered not only for Veterans but for how the nation conceived and responded to health challenges. In addition, I discuss the legacy of addressing the social determinants of health among Veterans in the VA health care system and why this became a part of the VA's health care model.

In Chapter Three, I explore three health policy case studies to better understand how the quest for just healthcare for veterans plays out in everyday practice and the policy process. Each of these case studies follows health policy formation as it unfolds to better understand the effects of VA's structuring power. These case studies reveal a competitive struggle to give that is constitutive to the health policy formation process. As I demonstrate, what was at stake was the chance for bureaucrats to meaningfully contribute to the policy process.

In Chapter Four, I explore arguably the most successful health IT innovation at the VA – the Blue Button. The Blue was a new idea that took root in the VA and changed business as usual as it relates to the ways in which patients could access their health care data. The findings about this particular case study reveal how ideas from outside of government can be taken up in new ways that impact health policy formation within it and the ways in which policies can escape control.

In Chapter Five , I build on the theme of successful reform by presenting another innovation the VA implemented; namely, using visual media as a structural health intervention in the form of the Make the Connection campaign. In describing this campaign, I draw upon literature in the anthropology of media in which media shapes identity (Ginsburg, Abu-Lughod, and Larkin 2002; Juhasz 1995; Spitulnik 1997) to contextualize the role that media plays in the construction of the archetypal warrior identity in popular culture and what this means for the work of the VA. As I demonstrate, the Make the Connection campaign builds on the theme of media and identity within the anthropology of media in interesting ways that raise questions about the ends to which state-media is used. What does it mean, for example, for the state to construct narratives about warriors that may not serve its interests? The VA's effort to populate the public sphere with a new archetype of the vulnerable warrior and an alternative story about the VA involves a cultural struggle over representation. Old representations about the strong warrior that returns even stronger from battle is giving way to a new representation of the vulnerable warrior who has physical and mental limits that can be broken.

In Chapter Six, I return to the initial question posed in the introduction about VA's tendency to fail by delving into the VA patient waiting list scandal of 2014, an

example of failure which occurred while I was studying the VA. I use the lessons from prior chapters to unpack what scandal actually does in the VA and what this means for health policy formation in the VA and at a large. In this final chapter, I build on Stevens argument that scandal represents a political opportunity in the VA to push through reforms that would otherwise be difficult (2016). I argue that the reforms discussed in the prior chapters set a cultural standard for health system transformation – "structural nonviolence" – that is in keeping with VA's quest to achieve just health for veterans. By unpacking the scandal of 2014 I reveal the other interests vying to re-shape VA's cultural standard for care and what this means for health policy at large. In making this argument I revisit the role of private interest in each of the prior chapters to demonstrate how health policy formation is a site where the fusion of public and private interest[9] represents a potentially powerful force driving the corporatization of the state. In this context, the VA represents a powerful deterring force that exerts a pressure on the American health care delivery system that influences its overall form. VA's power to influence is constitutive of the alternative cultural standard it sets for care which represents a threat to the cultural legitimacy of for-profit medicine which has dominated the American health care landscape.

Conclusion

This study has the potential to make several contributions to understandings about the mechanics of governmentality and reforming the delivery of health and health care in the U.S. One of the contributions this study makes to the anthropology of bureaucracy is

[9] Graeber discusses "the gradual fusion of public and private power into a single entity" as being a key defining feature of the "age of 'total bureaucratization'" (2015: 17).

to draw connections from inside of the VA to the outside effects the VA has on veterans bodies and in so doing highlight the institutional conditions that constrain health policy outcomes for veterans. Studying the inside workings of the VA as the lens through which its external effects on its constituents is best understood makes a critical intervention in the literature concerning structural approaches to health that have hitherto excluded the bureaucratic processes that can themselves be structuring and potentially obstructive to health reform efforts. In addition to being the largest integrated health care system, the VA also has the distinction of being the nation's oldest system of care. The next chapter reviews this history and what it means for better understanding how to improve care for all Americans.

CHAPTER TWO

THE HISTORY OF THE VA

Providing federal health services to American citizens was borne of the duty to care for veterans. The tradition of caring for veterans has deep roots in the United States that predate the formation of the nation. Following the legacy of England, the American colonies provided statutory benefits for veterans injured in the military service of the Crown (Adkins 1967). In 1624, the Virginia General Assembly passed the first law that promised to care for veterans: "…those hurte upon service to be cured at the publique charge; and, in case any be lamed, to be maintained by the country" (Glasson 1918).[10] These colonial origins took root and spread with several colonies passing similar legislation obligating colonial America to care for veterans. Eventually this duty to care expanded to include access to health services and after the Revolutionary War these laws were adopted by the new nation.

In a country whose history is notable for the absence of federal accountability for access to health services, until very recently, the care of veterans became the exception. Though the Department of Veterans Affairs (VA) would not exist in its present institutional form until the 20th century, its mandate to care for veterans existed as a collection of programs spread across various parts of the federal government since the 18th century (Adkins 1967). These roots formed the very first population health system in America and established the first federal responsibility to provide access to benefits and

[10] Of note, the Virginia Law was never ratified so the credit for the first enacted law governing the care of veterans was passed in 1636. According to Glasson the law stated: "if any man shall be sent forth as a souldier and shall return maimed he shall be maintained competently by the Collonie during his life."

medical services for American citizens. This legacy means the VA has the country's longest experience of improving population health. Since, literally, the birth of the nation, provisioning the care of veterans and provisioning population health in America was one in the same.

Drawing on this history of veterans' health policy, I argue that care of veterans during post-war periods in VA's history were critical moments of intervention that not only improved the population health of veterans but also greatly impacted the ways in which America conceived of and responded to population health challenges. The impact that VA's care of veterans had on larger conversations about improving population health in America is an untold story that speaks volumes about the institution's legacy. This chapter begins to contextualize this untold story by reviewing the history of the VA.

Special attention will be paid to the post-Vietnam War era of reforms and interventions to better understand the ways in which the VA has been at the leading edge of mental health reform and establishing alternative models of care. Questions this chapter will raise include: how politics started to inform perceptions about biology in the form of medical diagnoses; what the limits and constraints of the biomedical model mean for hard to reach populations; and how the emergence of "non-institutional care" in the form of the Vet Centers helped to operationalize the concept of biopsychosocial care.

Overview of Timeline

America's engagement with war and peace formed the VA. Protecting this county's liberty and preserving its union has always required war and rebuilding its future post-war has relied on the work of the VA to bind up "the nation's wounds"

(Lincoln 1865). These formations tie the legacy of the VA to the history of the United States (U.S.) which makes writing the history of the VA an exercise in tracing the links between the care of veterans and the rise of a nation. In post-war America, caring for veterans is how the nation heals not only the physical wounds of violence, but also its political and civil strife. This makes the work of the VA central to the civic life of the country.

Nowhere is this clearer than in President Lincoln's second inaugural address. Delivered after the country was ripped apart by the Civil War, President Lincoln's prescription for healing the nation was "to care for those who have born the battle" (Lincoln 1865). These words have since become the guiding motto of the VA and the context of his full speech reveals the connections between the rise of the American nation post-war and the need to care for its heroes.

> With malice toward none, with charity for all, with firmness in the right as God gives us to see the right, let us strive on to finish the work we are in, to bind up the nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan, to do all which may achieve and cherish a just and lasting peace among ourselves and with all nations (Lincoln 1865).

These origins point to a large irony about the origins of improving population health among Veterans: the duty to care in America was borne of war. The histories of other developed nations reveal a similar association that evolved in the 18th century with the emergence of nations and large-scale wars. The prominent 20th century historian and social critic Michel Foucault has written lucidly about these co-occurrences. Foucault writes:

> In all history it would be hard to find such butchery as in World War II, and it is precisely this period, this moment, when the great welfare, public health, and medical assistance programs were instigated… One could symbolize such a coincidence by a slogan: Go get slaughtered and we promise you a long and pleasant life. Life insurance is connected with a death command (1988: 147).

Though Foucault's wording is extreme, his analysis is relevant: state interest in providing care through the provisioning of medical services, public health and benefits has often required nations responding to the consequences of war. These war-torn roots of provisioning health echo what President Lincoln articulated 150 years ago and bind us today. With the recent end of America's longest wars in Iraq and Afghanistan, we embark once again and "strive on to finish the work we are in" (Lincoln 1865). As we enter yet another post-war period, the care of veterans continues to be a leading edge for the forms that improving population health takes in America.

The timeline below is a review of the major efforts undertaken by the VA to improve the population health of veterans. Of note, because the American system was deeply influenced by the European experience of caring for veterans, a few key dates in the timeline reflect major changes in England and France that influenced the care of veterans in the United States. This timeline is meant to serve as a summary of the ways in which the VA has conceived of and responded to improving the population health of veterans.[11]

[11] These dates and quotes were taken from the Wall of Veterans History exhibit at the VA New York Regional Office in New York, NY on February 15, 2015.

1593: The English parliament passed "An Acte for the Reliefe of Souldiours"
1624: Virginia General Assembly passed a law that promised: "…those hurte upon service to be cured at the publique charge; and, in case any be lamed, to be maintained by the country according to his person and quality."

1644: Maryland General Assembly passed an act providing that "every person that shall adventure as a soldier in any warre in the defence of the Country, and therein happen to be maimed or received hurt, shall, according to his place and quality, receive maintenance for the Country."

- Similar legislation passed by other states: New York, 1691; North Carolina, 1715; New Hampshire, 1718; Rhode Island, 1718; South Carolina, 1747; Georgia, 1755; and Delaware, 1756; New Jersey and Pennsylvania, 1777.

1670: King Louis XIV of France established the Hotel des Invalides for the care of aged and disabled Veterans.

1718: Among the colonial laws, New Hampshire's is notable for being the only one that mentions *payment* of medical care. The name of the law being "An act for the payment of cure of soldiers that are wounded".

1749: Seamen's hospital opened in Charlestown, South Carolina.

1788: Seamen's hospital opened in Norfolk, Virginia.

1798: President John Adams signs into law an act to provide for the relief of sick and disabled seamen. This led to the formation of the (merchant) marine hospital system which later developed into the U.S. Public Health Services.

1804: The first "marine hospital" is built in Charlestown, Massachusetts. Throughout 19th century marine hospitals came into being at inland ports and coastal ports.

1833: Congress authorized the establishment of the Bureau of Pensions, the first governmental unit devoted solely to helping Veterans. It was overseen by the Department of War.

1851: U.S. Soldiers' and Airmen's Home opens in Washington, D.C.

1855: The Government Hospital for the Insane, later named St. Elizabeth Hospital was opened in Washington, D.C. to treat the mentally ill of the Army, Navy and D.C.

1865: President Lincoln signed legislation creating the National Asylum for Disabled Volunteer Soldiers and Sailors, later named National Home for Disabled Volunteer Soldiers and Sailors. These were places of residency for aged and infirmed veterans that were incorporated into the veterans' health care system in 1930 and eventually became hospitals.

1884: A number of additional National Homes built.

1914: Congress created the Bureau of War Risk Insurance in the Treasury Department to insure ships, cargo, and crew members with the outbreak of WWI.

1921: Veterans Bureau was created by the federal government to consolidate programs for Veterans that were scattered between the Bureau of War Risk Insurance, the Federal Board of Vocational Education and parts of the Public Health Services that provided medical care to Veterans.

1922: 57 U.S. Public Health Services hospitals turned over to the Veterans' Bureau and became the nucleus of the VA hospital system.

1924: The World War Veterans Act liberalized veterans benefits and included the presumption that certain diseases or injuries which did not develop until after separation from service, were in fact, caused by service. The first two of these "presumptive conditions," tuberculosis and neuropsychiatric diseases, were considered service-connected if symptoms appeared within 2 years of discharge. This established the legal basis for the system's role as a national safety net.

1930: Congress authorized the consolidation of the Veterans Bureau, the Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers into a single, independent agency - the Veterans Administration.

1946: Omar Bradley creates the Department of Medicine and Surgery, separating the administration of medical services from non-medical services in the VA; National Mental Health Act passed.

1977: National Academy of Science Report on the Care of Veterans recommends that VA be "phased out".

1979: Public Law 96-22 established the Readjustment Counseling Service's (RCS) Vet Center Program. Vet Center Program created.

1988: VA became a cabinet-level agency.

1995: Ken Kizer was sworn in as Undersecretary of Health and led a transformation of VA health care delivery that catapulted VA from a poor-performing system to a leader in health care delivery.

2009: President Obama appointed Secretary Eric K. Shinseki to lead a massive transformation of the VA into a high-performing 21st century organization to better serve Veterans. Under the leadership of Secretary Shinseki, the VA has adopted three guiding principles to govern the changes underway, namely being people-centric, results-driven, and forward-looking.

2014: Secretary Shinseki steps down amidst scandal and accusations of management failures and Bob McDonald is appointed to become new Secretary of VA. Secretary McDonald is charged with turning the organization around.

Caring for the Disabled Soldiers

The ways in which learning from the care of veterans has transformed larger responses to health is not unique to America. The care of the disabled soldier post WW I in Europe led to profound changes in the way nations conceived of and responded to disability that are analogous.

> With the crumbling of the feudal system, and the development of standing armies during the fifteenth century, the professional soldier came into

> being. And from that time on, the disabled soldier was a recognized type (McMurtrie 1919a:14).

With the recognition of the disabled soldier came a shift in who was responsible for the care of disabled soldiers. What was largely an enterprise governed as an object of charity became the object of government (McMurtrie 1919b). This change in responsibility shifted the expectations that people placed on disabled soldiers by restoring the hope of self-sufficiency. Countries began to provide opportunities that enabled disabled soldiers to get back on their feet, like educational advantages and work that were previously denied. France was the first country to lead this shift by establishing the first trade school that targeted disabled soldiers in Lyon.

Figure 3, An Early Graduate From Ecole Joffre (McMurtie 1919).

The Mayor of Lyon, Edouard Herriot, opened the Ecole Joffre in 1914, shortly after the beginning of WW I, to train disabled soldiers and employ them in the local economy.

The Ecole Joffre provided instruction for a range of trades that lasted six to eighteen months. The demand was so great, that within a year, new schools began to emerge all over France and neighboring countries. The financing of these schools did not require charging the soldiers for instruction, room, board, or clothing. Moreover, for those not receiving pensions, a daily allowance of 20 cents was given.

Expecting more of disabled soldiers changed their fate. Even though they could not return to the same professions and jobs they held before their disability, the possibility of working again provided a path forward that was dignified and restored their place in the community. Up until that point, "public opinion [had] conceived the cripple as helpless and almost insisted that he become so" (McMurtrie 1919:20). Thus, what the Ecole Joffre and other pioneering schools for disabled soldiers represented was a fundamental shift in society's attitude towards the disabled that using any definition was more just.

Figure 4, Graduates of a Belgium disabled soldier's vocational school at work (McMurtrie, 1919).

The impact that the care of veterans made on attitudes towards the disabled is one example of how the care of veterans has always led to larger changes in how a society organizes its response to health. There are many more. For the purposes of this chapter, I will specifically review how the care of veterans in the United States shifted thinking about mental health. Of all the challenges that VA had to address, dealing with the mental health consequences of war has been the most difficult and enduring problem - a disability that continues to be a challenge to manage.

After WW II, ties between psychiatrists and the state emerged. With the establishment of the National Mental Health Act of 1946, psychiatrists entered centrality in the state coupled with a renewed faith in science, which was assigned new responsibilities in the service of national welfare. Federal responsibility for mental health grew out of concern that 1,767,000 were ineligible for military duty because of mental disorders (U.S. House of Representatives 1945). According to the congressional record discussing the National Mental Health Act of 1946, the fact that 50% of medical discharges out of the Army were due to psychiatric disease was causing national concern. "Unless prompt and vigorous action is taken", observed Congress, "the Nation has reason to expect during the postwar period a material increase in the volume of delinquency, suicide, homicide, and alcoholism – all of which are commonly symptoms of psychiatric disorders" (U.S. House of Representatives 1945: 2-3). Instead of constructing Veterans as "problems" as was done post-Vietnam, psychiatric disorders were characterized as the primary "problem".

At the time, more than 50% of the pensions being paid by the VA were attributed to psychiatric disabilities and more than half of the hospital beds in America were mental

health patients (U.S. Senate 1946). The National Mental Health Act was added to the Public Health Service Act and in 1948 federal money became available to address the challenge of mental health for the first time. Of note, the congressional record reveals a commitment to prevention was present in the federal response to mental health from the very beginning. The National Mental Health Act states:

> The national mental health needs lie in three principal areas: research to discover new and improved methods for both prevention and treatment; community services for more widespread application of existing knowledge; and training of more mental health personnel to carry on research, treatment, and training (U.S. Congress 1947).

These shifts in mental health funding set the foundation for the seismic shifts in technocratic understanding that took root in the post-Vietnam era.

Though mental disorders had emerged as a concern post-WW II, waging an effective response that named trauma for what it was would not happen until post-Vietnam. The VA's early response to the yet to be named diagnosis established a new model of care and established the sub-discipline of trauma studies. These two formations had a lasting impact that changed the way this country conceived of and organized its response to mental health.

VA's Response to the Vietnam War

The VA's experience establishing alternative models of care that include outreach services is tied to its institutional history caring for Vietnam Veterans. The legislative history requiring outreach first appears in the congressional record in association with meeting the needs of Vietnam Veterans. Public Law 96-22, signed June 13, 1979 established "Operation Outreach" (VA 1979: 1). This would later be renamed

Readjustment Counseling Services (RCS). The goal of this program was "to establish an outreach program to assist those veterans who have failed to make adequate socio-psychologic adjustment and reentry into civilian life" (VA 1979: 1). These origins began a legacy of alternative models of care in the VA that were tailored to meet the needs of the most difficult to reach, in this case Vietnam Veterans who did not trust the VA system. To better understand these developments in the VA, I must first contextualize the post-Vietnam historical moment in America.

A great deal has been writing about Vietnam Veterans and the circumstances surrounding the war that contributed to the difficulties they faced returning home. There is no doubt that the Vietnam War was unique in terms of the political and philosophical opposition at home. The unpopularity of the war among the American public led to regular protests that contributed to a hostile environment for returning veterans and shook the body politic of this nation. Of note, some of the most vociferous protestors were Vietnam Veterans themselves who had returned home. Vietnam Veterans Against the War (VVAW) became the first politically organized group "to formally and publicly oppose the war in which they fought while it was still in progress" (Scott 1993: 1-2).

The political goal of VVAW was to undermine support for the war and thereby lead to a withdrawal of all American troops in Vietnam. This was the first time in this country's history that Veterans had organized in an anti-war effort. It was VVAW's contention that the war was unjust and many other Americans believed the same. The Vietnam Veteran and sociologist Wilbur Scott has thoughtfully concluded:

> At issue were competing versions of what kinds of violence were justifiable in Vietnam as a matter of policy, and of the extent to which U.S. troops had committed atrocities- acts of violence against enemy

> soldiers and civilians that were unacceptable under the Military Code of Conduct. In one view, atrocities occurred rarely and American policy was sound; the rare atrocity was the work of the occasional "bad apple" who slipped through pre-induction screening or who violated regulations. According to the other view, atrocities were both frequent and the direct result of American military policy. The two versions symbolized more generally how factions of the American public viewed the war (Scott 1993: 2).

Regardless of which version was the truth, the divisions created by these competing views in American society were deep and created fertile grounds for political agitation.

The civil unrest that surrounded the Vietnam War greatly influenced societal perceptions about war and the psychological effects of war on Veterans. In the popular press, constructions of the Vietnam Veteran as "problem" gained traction with magazine articles describing them as "America's Human Time Bomb" and "The Violent Veterans" despite the fact that only a minority of returning veterans were experiencing readjustment difficulties.[12] This fueled public indifference to the experience of returning Vietnam Veterans and shaped the civilian response. This led one scholar to write that nothing "reflects so much of what is wrong with American society" as its treatment of Vietnam Veterans (Leventman 1975: 171).

VVAW used these conditions to agitate. Their members staged protests that emphasized the atrocities of war throughout the country. According to Scott, this focus had multiple purposes that were informed by the confusion and shame Vietnam Veterans had felt about their combat experience (Scott 1993: 12). These protests became public enactments that exposed the war for what it was in their view – wrong. The most

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[12] Breslin, C. & Jury, M. "America's Human Time Bombs," *The Philadelphia Enquirer,* August 20, 1972; "The Violent Veterans", *Time*, March 13, 1972.

dramatic of these protests was Operation Rapid American Withdrawal, depicted in Figure 5, in which Vietnam Veterans marched from Morristown, New Jersey, to Valley Forge, Pennsylvania dramatizing the atrocities of war (Sullivan 1970: 6).

Figure 5, Soldiers Marching in Operation Rapid American Withdrawal

"In a series of staged incidents, the marchers seized a private home just north of here and in a mock enactment of combat operation, terrorized its occupants, all of whom had agreed earlier to participate in the demonstration" (Sullivan 1970: 6). The executive secretary of VVAW explained to the *New York Times* that the protest had "been staged as realistically as possible without actually shooting anyone" (Sullivan 1970: 6).

This provokes the question: why did Vietnam Veterans go to such lengths to protest a war that they themselves fought in? What was different about Vietnam? According to Bill Crandell, and other VVAW leaders, part of the answer lay in a moral

claim – "people were killed for what didn't seem like a good enough reason" (Scott 1993: 12). But there were other distinguishing factors. Firstly, Vietnam Veterans were surviving wounds that would have killed veterans of prior wars (Kuramoto 1980). This observation makes sense in light of VA's own institutional experience caring for veterans from different eras. With the advancements in medicine and science, the wounded-to-killed ratio of war increases with time. This persistent occurrence meant there were large numbers of disabled veterans returning from Vietnam that had suffered multiple physical wounds. Secondly, there was also something completely new. Unlike World War II (WW II) or the Korean War, a new epidemiologic pattern of illness was emerging post-Vietnam: unprecedented levels of psychiatric problems *after* the war was over.

Naming Post-traumatic Stress Disorder

America's newfound awareness concerning war and its effects similarly engulfed the medical community that was treating returning veterans and they began to notice something different. Many of these clinicians practiced in the VA system. A VA psychiatrist recalls in an interview: "It was a bit of the Wild West back then. No one really knew what to do with the returning Vietnam Veterans. Their suffering was so raw and quite different from anything we had seen. It didn't fit any of the categories".[13] In an autographical essay by Matthew Freidman, the former Executive Director of the VA National Center for PTSD, for a compilation about pioneer trauma scholars, he explains further:

> Combat Veterans were flooding our clinics, occupying inpatient beds, and demanding that we do something to alleviate their angst and distress. We

[13] Interview with Staff Member #1, March 10, 2016

> didn't know what to do for them. Although they were sometimes depressed, guilt-ridden and suicidal, their problem certainly wasn't class melancholia. They reported vivid, emotionally-riveting enactments of war-zone scenarios that bore little resemblance to psychotic hallucinations. They were often extremely mistrustful about the US government, including the VA hospital system. Because of their overwhelming fears about personal safety, many carried firearms for protection wherever they went. And their rage at the government and American public fueled hair-trigger tempers that, not infrequently, erupted into sudden unexpected aggressive outbursts that were potentially dangerous to clinical staff (Friedman 2013: 3).

Friedman's description of Vietnam Veterans, as angry and untrusting, were part of the symptomatic expression of the yet to be named diagnosis - Post-traumatic Stress Disorder (PTSD). PTSD would not be officially recognized as such until 1980 with the publication of the third edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (American Psychiatric Association 1980).

The emergence of PTSD as a diagnostic category marked a watershed moment in the history of mental health in America. The details of this story are beyond the scope of this study and have been chronicled by many other scholars. The most definitive work on the subject was conducted by the anthropologist Allan Young and published in 1995 in his book *The Harmony of Illusions: inventing post-traumatic stress disorder.* However what is relevant for the present study is what the emergence of the diagnosis reveals about the large role the VA has played in shaping and informing mental health reform in America. Improving the mental health of Vietnam Veterans became a Trojan horse for the discovery and treatment of trauma in America. This fact is uncontested.

In an interview about VA's contribution to the national advancements in improving the treatment of trauma in America a VA psychiatrist further corroborates:

> ….people forget and I hate to say it because it makes me sound like an old man but in the old days PTSD and Vietnam Vets were synonyms. It was inconceivable that twenty-two years later we would not just be talking about Vietnam Veterans. I mean it was completely inconceivable that in the future we would be talking about rape victims and tsunami survivors. That we would be talking about plane crash survivors and on and on. I mean that just wasn't on the screen back then…. No one had connected those dots until PTSD.[14]

What the VA uncovered about Vietnam Veterans began a profoundly deep discussion about recovering from the mental health consequences of war and finally secured the resources and recognition necessary to combat trauma in America.

The VA's initial response to combatting trauma began with establishing a new model of care to serve Vietnam Veterans, namely the Vet Centers (later referred to as Readjustment Counseling Service). This new model of care played a critical role in determining what the professional accrediting bodies in America would include as part of the diagnosis of PTSD. A VA staff member involved with the Readjustment Counseling Service explains further:

> The diagnosis of PTSD in of itself, the history of it came after the Vet Centers program had started and it was recognition out of the field, a convergence that these Veterans were coming in with symptoms and the way that they reported these symptoms generated a viewpoint that maybe combat stress can lead to consequences. It [the diagnosis] actually reflected the struggles of the Vietnam Veterans who came back and were not accessing the VA medical centers. They felt it was too bureaucratic. So all the things that we are now doing for the OIF/OEF Veterans arose from there, which was to remove the barriers to care, create an entry level where they could come in, meet someone else, usually their peers and

[14] Interview with Staff Member #1, March 10, 2016

> begin to address the psychosocial issues from the war.[15] But they were not accessing care because at that point psychiatrists were not seeing PTSD.[16]

The fact that the medical diagnosis of PTSD reflected "the struggles of the Vietnam Veterans who came back and were not accessing the VA medical centers" reveals a very interesting convergence of technical and social understanding that emerged post-Vietnam. Up until this historical moment what was included in technical definitions of clinical diagnoses was solely decided by medical professionals and scientific experts. But in the case of PTSD, the boundary between biologic fact and social values became more porous. Politics started to inform perceptions about biology in unprecedented ways that eventually empowered veterans to make a legitimate claim regarding what medical professionals and scientific experts should include in a technical definition.

Vietnam Veterans literally shared responsibility in deciding what the technical definition of PTSD would become. They shared this responsibility with VA clinicians and experts throughout America and were even included in the American Psychiatric Association's committee that was charged to codify the definition. The inseparable ways that social and technical understanding informed each other post-Vietnam to shape what the diagnostic criteria of PTSD became is a testament to the political efficacy of Vietnam Veterans and their efforts to demand America to envision collective responsibility for their health.

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[15] OIF/OEF refers to the military names for the Iraq and Afghanistan wars which were Operation Iraqi Freedom and Operation Enduring Freedom, respectively.
[16] Interview with Staff Member #2, April 15, 2016

This has large implications for health policy and improving population health in America that concern the ways in which different stakeholders coordinate their efforts. The congressional record is replete with testimonies that weave the experiences of VA clinicians, Vietnam Veterans and other advocates into a larger story about the formation of America's response to trauma. This history begins with the establishment of the Vet Centers and the alternative model of care they represented.

Mobilizing Empathy: The Vet Center Way

In 1979, Public Law 96-22 established the Readjustment Counseling Service's (RCS) Vet Center Program. Examining the conditions that led to this development in the congressional record reveals the social and political formations of a new model of care that was rooted in the community and led by Veterans. It took 10 years of advocacy to realize the Vet Center Program and the Administrator of the VA who was responsible for implementing the program, Max Cleland, was himself a Vietnam Veteran that played an active part of the advocacy effort prior to his arrival to the VA.

In December of 1969, Cleland testified in the first set of hearings that the Senate Veterans Affairs Committee held to examine the treatment of Vietnam Veterans by the VA. He began by pointing out the unique traits that distinguished Vietnam War Veterans from other era Veterans.

> The wounded Vietnam Veteran is unique in two responses from his predecessors. First, he is more likely to have a permanently disfiguring and disabling injury and to survive it than any of his predecessors. Secondly, he is more likely to have doubts about the validity of his sacrifice. The odds are that I would not be here before you today if I had received the same wounds in World War II or Korea. I was involved in an

> accidental grenade explosion near the Khe Sanh the week the siege there was broken in April 1968. Luckily, rapid medical evacuation by helicopter was available, along with quick first-aid, improved surgical techniques for treating shock, and rapid evacuation to support hospitals in Japan (Senate Veterans Affairs Committee 1969: 279).

Cleland had lost both his legs and his right forearm in the Vietnam War. He embodied the link between personal experience and public advocacy that had been at the center of Vietnam Veterans organizing efforts. This association reflects the profound role that empathy played in crafting a new model of care for wounded Vietnam Veterans. In Cleland's case, having empathy for Vietnam Veterans went beyond his triple amputee status it was also about the mental consequences.

> The inevitable psychological depression after injury, coupled with doubts that it may not have been worth it, comes months later like a series of secondary explosions long after the excitement of the battlefield is far behind, the reinforcement of your comrades-in-arms a thing of the past, and the individual is left alone with his injury and his self-doubts. Anyone who deals with a Vietnam returnee, wounded or not, must understand this delayed, severe psychological symptom. And, in my opinion, more effort has to be made, especially by the VA, to ensure that the small but select minority of Vietnam returnees in VA hospitals have adequate social, recreational, and psychological activities to help them in readjusting to American life (Senate Veterans Affairs Committee 1969: 284).

Ten years after speaking these words, Cleland was appointed to be the Administrator of the VA by President Carter at the tender age of 34. Congress had passed Public-Law 96-22 and he was now responsible for implementing the Vet Center Program. The main task at hand was resource connection. In the words of congress: "The purposes of this readjustment counseling provision is to make fully available – and to encourage

and facilitate the full use of- the resources of the VA's health-care system to those Vietnam-era veterans" who needed it. By this point, studies had revealed an average gap of 5 years between the time of discharge from the service and the first attempt at seeking VA help (Senate Veterans Affairs Committee 1977). There was even some evidence indicating it was closer to a gap of 7 years for younger Vietnam Veterans (Senate Veterans Affairs Committee 1977). Linking Veterans into care became the main goal. The question was how?

Part of the answer lay in the ways that readjustment was defined. Legally, a "readjustment problem" was defined:

> … to be a low-grade motivational or behavioral impairment which interferes with a veteran's normal interpersonal relationships, job or educational performance, or overall ability to cope reasonably effectively cope with his or her daily life problems. A readjustment problem does not usually amount to a definable psychiatric illness requiring extended professional services but could become such an illness in absence of early detection and counseling and follow-up care where necessary (Senate Veterans Affairs Committee 1979: 27).

I would argue what is interesting about this definition is its liminal status somewhere between medicine and society. The affordances this positioning offered began to shape what forms the outreach would take. Helping Veterans cope with the everyday problems of social life became new terrain for the VA to use and target. The fact that a "definable psychiatric illness" was not necessary for the veteran to have in order for the VA to intervene also set a focus by default on the prevention of mental illness.

This definition enabled the Vet Centers to set a new foundation for a model of care that was tailored to meet the new liminal tasks of readjustment. This alternative model represented a departure from the biomedical model of services that dominated the VA health system. Establishing something new against this background would not be easy. To appreciate the enormity of the challenge the Vet Centers faced in developing and implementing a new model of care within a VA health care environment that preferred the biomedical model, I must first explain what this dominant model means.

The biomedical model is the dominant view of disease in the Western World "with molecular biology its basic scientific discipline" (Engels 1977: 133). The model was developed by medical scientists and relies heavily on scientific methods. Within this paradigm, the mind is separated from the body and the biological phenomena of the body are best explained using the language of the physical sciences. These characteristics are defining features of the biomedical model that have been described as reductionist and dualistic for dealing with disease as an independent entity apart from social behavior. These methods serve as the main explanatory frame for disease and drive scientific research both inside and outside the VA; in the past and the present.

In light of this context, what the experience of Vietnam Veterans brought into sharp relief for the VA were the limitations of the biomedical model. The normative demands of this model fell short when it came to helping Vietnam Veterans readjust. The VA had to come up with something entirely new and non-institutional. Waiting for Veterans to come to the VA was not going to cut it. VA clinicians were already starting to test the waters of what this meant. A VA staff member who helped spearhead VA's early response to PTSD recalls:

> When the legislation to set up the first Vet Centers came to be…I had been working with Vietnam Veterans since 1974. In fact I had a group of veterans that met in my home, …we had a term in those days for those who "couldn't get past the brick". So this was for the people who wouldn't come to the VA hospital.[17]

This aversion to institutions that some Vietnam Veterans shared shaped the Vet Center's non-institutional focus and informed their community-based approach.

With the focus on readjustment and outreach, a new model of disease was needed that was anchored in the relationship between the social environment and behavior. Interestingly, about two years prior to the passage of Public Law 96-22, this missing model was first articulated in the medical literature – George Engel's biopsychosocial model of disease (1977). My research reveals that Engel's model is never mentioned in the congressional record or the internal documents of the VA but its contemporaneous evolution is significant because it presents a scientific frame for the Vet Center's approach that can be used to extend the significance of what this new model of care meant for larger conversations about improving population health in America.

At its core, the biopsychosocial model is an organizing construct that places behavior and system complexity central in the explanatory framework of disease. Whereas the biomedical model excludes psychosocial factors or tries to reduce them to "physiochemical principles", the biopsychosocial model widens the frame of relevant information to include behavior and in so doing restores a degree of complexity that the

[17] Interview with Staff Member #1, March 10, 2016

biomedical model erases. Holding psychosocial issues central, means recognizing the personhood of patients and acknowledging that they are more than a collection of organs that have definable disease. It also means explaining disease as a product of complicated relationships between body, mind and environment.

Perhaps the single most important goal of Engel's model is its quest to recover a place for behavior and social context within a scientific paradigm that fits into the social world of physicians. It restores the complexity that the biomedical model reduces by incorporating the social determinants of disease in a framework that allows clinicians to include these variables in their analysis. Thus, in many ways, the biopsychosocial model is nothing more than a reframing of the boundaries that are important to consider for responding to disease. It makes room for the psychosocial processes that are just as relevant as the biological processes and in so doing creates a guide "to the systems that the physician [should] keep in mind when undertaking the care of a patient" (Engel 2003: 7).

The Vet Center program was the first *national* biopsychosocial model in practice. This frame has never been claimed. I traced the development of the Vet Center Program through the VA's internal administrative documents to demonstrate how the core tenets of the biopsychosocial model were taken up in the governing of population health for Vietnam Veterans. The adoption of this model by the Vet Center staff was further facilitated by a model of care that relied almost exclusively on combat Veterans providing the care. Mobilizing the experiences of Vietnam Veterans to serve as peer educators for other Vietnam Veterans was a new methodology in the 1970s. Relying on combat veterans who fought in Vietnam to reach out to other Vietnam Veterans who

were struggling with readjustment harnessed the power of empathy and employed it in the service of improving population health. Peer-led services have since been identified as effective tools for improving outcomes in health care and prevention (Fisher et al. 2014).

The Readjustment Counseling Services (RCS) at the VA eventually established a radically new model of care with the creation of Vet Centers. These "storefront counseling centers" operated independent from Veterans Administration Medical Centers, and always have (U.S. Congress 1981). This separation extends into their medical records which are kept confidential from the larger VA system. The rationale for the autonomy of the Vet Centers is documented in the congressional record:

> The program was initially established with a unique degree of autonomy, as agreed by the VA and the Congress, because of the inherent distrust of the Vietnam Veteran toward the traditional, established institutions of the health care delivery system currently operated by the VA (U.S. Congress 1981: 2).

This freedom afforded the Vet Center program to be what it needed to be and where it needed to be. Storefronts, large houses, shopping centers, and any other physical building not connected to a government building became the physical spaces that would house the program. It also meant instead of using preexisting professional disciplines and treatment methods to organize the response, the Vet Center model could exclusively use the needs of their target population to organize their services. The initial staff of each Vet Center was comprised of four people: one mental health professional (psychologist, social worker, psychiatrist, or nurse), two professional or paraprofessional counselors, and one office manager (Blank 1985).

The first few years implementing this program represented a steep learning curve that was iterative. This process is easily traced in VA's internal administrative documents which begin to operationalize the meaning of Public Law 96-22 into a set of actions that were community-based and peer driven. The core provisions of the Vet Center program as initially articulated in the Report on the Committee on Veterans' Affairs of the United States Senate (April 7, 1979) were as follows:

- Readjustment counseling is to be readily available on an outpatient basis and all unnecessary barriers to help are to be removed.
- Readjustment counseling does not imply mental illness and does not necessarily require a psychiatric diagnosis.
- Readjustment counseling programs will be located in local communities with easy access for the veteran population.
- Readjustment counseling includes psychological assessment and direct counseling services.
- Readjustment counseling includes services to the Veterans' family members when necessary for the readjustment of the Veteran.
- Readjustment counseling will be provided by a mix of mental health professionals and paraprofessional peer counselors
- Readjustment counseling will include an extensive outreach program to directly inform local Veterans about available services and create active liaisons with existing community agencies and Veterans' groups to facilitate Veteran referrals.

The main outcomes of successful readjustment as defined above for the Veteran can be summarized as: recovery from physical and mental wounds; recognizing that the strategies of survival in combat are ill-suited for civilian life; incorporating war experiences into civilian selves; and reestablishing their familial and occupational careers (Scott 1993).

The program was initially established for five years because at that time there was a belief in some circles that it would take only three years to identify all Veterans with PTSD and another two years to cure them. However, after pilot testing five Vet Centers

to demonstrate the feasibility of this unprecedented community-based approach, the program grew rapidly and exceeded all expectations. The great consumer appeal combined with a higher than anticipated utilization reflected that a need was being met. On November 21, 1983, Congress passed Public Law 98-160 which established readjustment counseling as a life-time eligibility. By 1990, over one million persons had been seen for services in the Vet Centers with only 45 received letters of complaint regarding the program (Blank 1993).

Making The Connections: Linking Formal and Informal Networks Of Care

The Vet Center program currently consists of 300 Vet Centers dedicated to providing individual and group counseling for Veterans and their families, bereavement counseling for families who experience an active duty death, and counseling in many other areas such as military sexual trauma, substance abuse, employment and Veterans benefits. Families are an increasing area of focus as well. Beginning in FY 2010, RCS recruited additional staff to assure that a qualified licensed Family Counselor is on staff at every Vet Center. The Vet Centers continue to provide safe and confidential community-based settings where combat Veterans can speak openly about their war-related experiences with the confidence that their records will not be released without informed consent.

The national staff is still largely comprised of veterans. Approximately 75% are veterans, 60% of whom have served in a combat zone. Over 35% of staff members have served in Iraq and Afghanistan. Providing peer-led services continues to be the backbone of the Vet Center system because of the ways peer relationships promote camaraderie,

empathic connection, trust, and quality readjustments services to combat veterans and their families. A staff member describes the modern day RCS Program as being a public-health oriented program. "We are trying to treat the whole person and we actually practice a public health model meaning early intervention and prevention".[18] He continues to explain:

> We try to get them early through outreach, stabilize them, normalize the process, thread that out, connect them and as they show a need, get them into the psychiatrist. And there is a need for that, you need to figure those out and get them in. And then we usually get them back. The way the medical system works right now, if you walk into a medical center, you are not likely at all to be referred to a Vet center. Cause their concept is still very medical and very oriented towards cure/curing something.[19]

This chasm between a "very medical" system and what the Vet Centers practice mirrors a larger divide in the American health system. Despite the success of the Vet Center experience, the biopsychosocial model of care never took root in America. The biomedical model of disease still reigns supreme, even within the VA.

The fact that the Vet Centers proliferated despite this context means the value they provide is related to what their model of care provides as a complement to more traditional systems of care. The Vet Centers support the biomedical model of care by engaging the informal networks of care that surround Veterans – especially their families – and employing them in the service of managing risk. Their experience engaging family members to help coordinate the care of Veterans is a powerful mechanism of care linkage that connects informal networks of care (family and community) with the formal

[18] Interview with Staff Member #2, April 15, 2016
[19] Interview with Staff Member #2, April 15, 2016

networks of care that exist in the VA. Making this connection extends and includes a diverse range of actors as part of the care giving team. Placing the care that families provide on equal footing with the care that VA clinical providers and Vet Center staff deliver weaves a stronger network that can collectively assume responsibility for helping veterans readjust.

Connecting informal and formal networks of care is the shining strength of the Vet Center Program. This strength has a great deal to teach other health systems that are interested in developing alternative models of care within a system of care that still prioritizes the biomedical model. Providing room for alternative models of care to co-exist and mutually respect each other is a challenge. Though the Vet Centers bring a great deal of Veterans into the formal medical care system, the reverse referral from the formal medical care system into the Vet Centers is rare. According to a staff member, "the way the medical system works right now, if you walk into a medical center, you are not likely at all to be referred to a Vet center…because their concept is still very medical and very oriented towards curing something".[20] His comments demonstrate that sharing the collective responsibility for health is often unequal though it need not be. The struggle to equally share care is reflected in the history of administering the Vet Center Program.

Maintaining the unique role the Vet Centers play and ensuring it is not usurped by the larger medical programs is difficult. Said one staff member of this challenge:

> In the beginning it was tough, it's still tough. Maintaining our role is tough. I have gotten in so many fights over the years with Medical Center

[20] Interview with Staff Member #2, April 15, 2016.

> directors who do not consider what we do as treatment. A lot of them just don't get it.[21]

The internal VA documents prove this conflict was present from the very beginning. According to one of these institutional documents:

> The Vet Center was initially administered by VA's Mental Health and Behavioral Science Services (MHBSS). The Mental Health Director at the time refused to implement the contract readjustment counseling part of the program because he believed it was not operationally feasible. Congress had specifically authorized VA to implement readjustment counseling through private sector providers under contract with VA to facilitate services for veterans living at a distance from exiting Vet Centers. As a result significant amounts of funding authorized by Congress for the program remained unutilized (VA Readjustment Counseling Service 1993: 3).

This is largely due to claims of legitimacy about what constitutes technical treatment from the perspective of the larger biomedical system and where treatment is to be delivered. A staff member explains that in the beginning, "the existing models of psychiatric care were inside the medical centers and the Vet centers were outside the system."[22] This is where the fights over legitimacy began. Defining who has control over what constitutes treatment and care is a larger question that will be further reviewed in the subsequent chapters. However, regardless of the challenges the Vet Centers have faced in their past and present, their contribution to improving the population health of the hardest to reach veterans has been an enduring model of care linkage with much to offer.

[21] Interview with Staff Member #2, April 15, 2016.
[22] Interview with Staff Member #2, April 15, 2016.

Conclusion

The VA's history of being at the forefront of the discovery and treatment of trauma in America is a powerful exemplar of the ways in which the institution has impacted national conversations about health. The naming of PTSD among veterans opened an entirely new field of trauma studies that has since flourished and started a new chapter in the history of mental health care in America. The VA continues to be a pioneer in addressing trauma through its research program which has developed the most effective treatments for PTSD.

To a remarkable extant, VA's history caring for Vietnam Veterans, also brought into sharp relief the limitations of the biomedical model to health care and the need to include social problems as part of the response to health issues. The evolution of the Vet Centers and their alternative model of care that focused on biopsychosocial care provides a blueprint for how healthcare institutions can begin to approach outreach and establish alternative models of care alongside more traditional models of delivery that consider the social determinants of health.

CHAPTER 3

MAKING HEALTH POLICY

In this chapter I explore what health policy is like *in vivo*, in real life. More specifically I explore the everyday work of the VA in making veterans' health policy at the cabinet level through the prism of three case studies where new policy was formed: 1) the first ever joint VA and Department of Defense (DOD) Mental Health Summit and its resulting policies; 2) the passage of a new Agent Orange act; and 3) an interagency policy committee process focused on strengthening the nation's support of military families. Studying how health policy is made at the highest levels of government is a rare opportunity to "study up" gradients of power and more specifically, better understand how powerful bureaucracies and those in power operate to shape and constrain the outcomes of health policy for veterans. Looking at the everyday practices of this large bureaucracy affords the chance to better see the institutional conditions and dynamics that produce the VA's effects on veterans health policy. The iterative everyday practices of the VA are also performative in that they constitute the core of the VA. I document these re-enactments in this chapter to understand how the structure of bureaucratic authority contributes to the process of health policy formation (Gupta and Sharma 2009).

As mentioned in my introductory chapter, my work builds on a large literature in anthropology that studies "up" gradients of power (Nader 1974 [1969]). In this literature, power, governmentality, and bureaucracy may all be viewed as interrelated terms that shed light on the ways that policies are crafted and implemented in modern society. This study explores these themes by examining the ways in which laws and policies that affect

veterans' health issues are implemented at the VA. This study builds on a literature in the anthropology of policy. The main question an "anthropology of policy" poses is: "how do policies 'work' as instruments of governance, and why do they sometimes fail to function as intended?" (Shore and Wright 1997: 3). In order to answer this question, the relationship between power, governmentality, and bureaucracy must be fleshed out. Each term/concept represents a connected sphere of influence in the anthropology of policy that shapes the ways in which policies are implemented. Moreover, all three terms can be positioned as evolving concepts that work together to frame the ways in which laws and policies become part of the complex processes that shape contemporary societies. Positioning policy as a subject of anthropological analysis becomes a way of delving into each of these concepts in a way that problematizes them and reveals unexplored dimensions of each. Within this larger literature, there is a dearth of studies about "the main occupation of contemporary states: administration, regulation, delegation" (Bernstein and Mertz 2011). The chapter will contribute to this gap in knowledge by examining three separate case studies that present windows into the administrative and legal powers of the VA in its everyday life of taking care of veterans.

The three health policy case studies I present in this chapter provide three different snapshots of what making veterans' health policy looks like in practice as well as in effect. These case studies also disentangle intention from outcome and show how and why despite the best of intentions, consolidated political will, and budgetary resources the VA continues to fall short of its mandate. By foregrounding the heterogenous nature of the object under study, I argue that the formation of health policy at the VA is best understood as a "global assemblage" (Ong and Collier 2005). "Global

assemblages are the actual configurations through which global forms of techno-science, economic rationalism, and other expert systems gain significance. The global assemblage is also a tool for the production of global knowledge" (Collier 2006: 400). Scholars have pointed out that "global" in this usage "refers to forms such as science, expert systems, or techniques of rational calculation whose validity, as Anthony Giddens has argued rests on 'impersonal principles, which can be set out and developed without regard to context'" (Giddens in Collier 2006: 400). The global assemblage of health policy in the VA context is comprised of links between bureaucrats, institutions, technologies, disciplines and discourses that function to stabilize dominant modes of thinking about health issues or disrupt them. This observation builds on a literature in the anthropology of policy that describes the process of policy formation as a space of political contestation (Shore and Wright 1997; Shore, Wright, Pero 2011).

Positioning health policy as an assemblage provides a useful scaffold to understand the differences across the case studies I discuss below which demonstrate both the fragility of hegemony within the state as well as the varying ways expert knowledge is used to either bolster or destabilize it. This dynamic is tied to power and more specifically Gramsci's concept of hegemony which he describes as a continuum between consent and force. According to Gramsci, the state is implicated in both forms of power:

> …the State is the entire complex of practical and theoretical activities with which the ruling class not only justifies and maintains its dominance but manages to win the active consent of those over whom it rules (1971: 244).

The state is both a dictatorship that uses force and coercion as well as hegemonic in the ways that it shapes consent (Crehan 2002: 103). Nonetheless, hegemony is fragile, even within the state. Hegemony is being constantly challenged by alternative ideologies and is thus in need of constant maintenance and can be seen as a "continuous process of formation" (Forgacs 2000: 423). Thus the power that the state exerts is not totalizing, as all three case studies reveal.

The first case study explores the first ever VA-DoD Mental Health Summit and its resulting policies. This case study shows the formation of health policy as an intense site of competition at the VA where bureaucrats, policy makers, and technocrats are all competing. This competition is fueled by the moral resources the VA makes available to all who work there which stems from its noble mission: "To care for those who have borne the battle"[23]. The moral resources that this mission makes available to its employees has the potential to strengthen the moral vision of government but it also has "side effects" that fuel a fierce competition for honor that I document ethnographically (Ferguson 1990). To my surprise, the relationship between honor and politics I witnessed at the VA was agonistic.

The second case study explores the contested passage of a new Agent Orange law. and the contestation from beginning to end. This new law grants disability payments to veterans exposed to Agent Orange. "The passage of law is one moment in a process of appropriation and contestation when a political coalition succeeds in silencing others, making their version authoritative and embedding it in the precepts and procedures of the

[23] Abraham Lincoln, March 4, 1865, Second Inaugural Address

state" (Shore, Wright, and Pero,2011:13). Key questions that are explored in this case study include: whose views prevailed in becoming hegemonic and why? What were the consequences? The Agent Orange case study also sheds light on the different ways in which uncertainty is managed by expert knowledge systems, in this case science and law, and what happens when these systems clash. In the case of the Agent Orange presumption decision[24], administrative law subverted scientific claims to certainty by relegating the need for causal certainty, the gold standard in science, secondary to legal obligations.

The third and final case study explores Presidential Study Directive 9 which culminated in Michelle Obama's and Jill Biden's Joining Forces Initiative. The former was the result of an interagency policy committee process that aimed to develop a coordinated Federal Government-wide approach to supporting military families. I examine the role that documents, Power Points, and presentations played in policy formation as well as the rise of the military family as a discourse. Foucault describes discourse in its simplest form as "an individualized group of statements" and a "regulated practice that accounts for a certain number of statements" (1972: 80). It is both the content of the language it includes and the way the language is used. The practice of discourse puts the group of statements into circulation. Thus, discourse is constituted by content, practice, and circulation.

All three cases show the practical power the VA has in implementing new policies that have profound effects on the lives of veterans. This translational power

[24] A presumption is a special category of policy whereby the burden to establish proof for an entitlement are foregone.

means that the VA is not only responsible for drafting the policy proposals and researching them it must also implement.

Embodying Power and Goodness

As I mentioned in my introductory chapter, the White House Fellowship provided my entry and access into an elite network of governance at the Cabinet level. The fellowship was a supreme window into how policy gets made. More specifically, having chosen to be placed in a health agency that also happened to be our nation's largest health care system, my access provided a direct window into how health policy gets made. What I learned very quickly in those first few weeks of service is that power extends into all spheres of life in Washington. It's very sticky. Having trained in elite environments, namely ivy league undergraduate and graduate schools, I assumed there would be nothing new about being around status, prestige, and power. But I was wrong. This was different. The cafés, restaurants, and bars are teeming with power brokers networking, wielding, and dealing this currency. This means even having a drink after work is not without consequence. At first, this all seems social and almost harmless. But after some time, the expectations that come with being social start to feel exhausting because it is more than socializing.

One of the first instances I noticed was that having a drink or dinner after work was more work involved an interaction with a leader of a nonprofit that was focused on launching new programs to help military families. He had met me in my office a couple of times with respect to supporting military families as part of the First Lady's initiative, which was called Joining Forces. What struck me as strange, eventually, was the persistence with which he would schedule meetings to discuss "ideas". His interactions

during these meetings were always appropriate, by which I mean I never felt uncomfortable. But what I did notice was that they made me tired. After my fourth meeting with this individual was scheduled to discuss the mental health support programs his organization was establishing, I did something unusual – I cancelled the meeting. Though I did not understand why I felt the need to do this at the time, I did remember how it made me feel – it felt like I was cutting ties with that person despite his best efforts to stay connected.

The vigilante creation and maintenance of social relationships in government was part of being an effective political operative. Leveraging these connections is how work gets done. Interestingly these relationships were not necessarily new. One of the first observations I made at the VA was how many of the senior staff had some connection outside the VA. For example, the Deputy Secretary of the VA was a mentor to many of the political appointees and one of his protégés worked in the Strategy Group with me. He had what I would describe as favored status in all workings within the strategy group. Whereas I could easily get bumped off a meeting schedule, he never would. He was always recognized and supported in all his endeavors. At every turn the institution was setting him up for success. My experience was altogether different. It felt like I had to prove myself at every turn. Nonetheless, in my year working at the VA I was very eager to learn as much as I could about making policy and my enthusiasm offset any challenges. But early on, I could tell that something was very unique about the VA and it piqued my interest.

As part of my White House Fellows placement process, I interviewed at a range of agencies but my interview at the VA left a real impression. It was clear that there was

a greater sense of mission, above and beyond civil service, that energized everyone who worked there and I was intrigued.[25] So even before I started working there, I could tell that there was something that set the VA apart from the other departments in government and it had everything to do with the its organizational mission. The Deputy Secretary summarized the mission to me early in my time at the VA as being about "fulfilling a moral obligation to doing right by veterans which meant advocating for them and making sure the VA transformed itself into a leading 21st century institution". Moral obligation, advocacy, and transformation are all lofty, aspirational terms that are laden with affective meaning. During my interviews with staff, I further learned that VA employees feel strongly about this work and mission. One staff member explained: "The mission of this place is why I will never leave. My first job out of college at the VA was working at a clinical lab and 35 years and two graduate degrees later I am still here. What we do matters and it makes me feel good."[26] Other staff members echoed similar sentiments. "I just love the veterans. There is nothing more fulfilling than making sure they get what they deserve".[27] These employees sentiments show that working at the VA allows employees to be moral, in other words to identify themselves as good people. In another staff interview, an employee further explains this point:

> I never thought about credit much until I started working here. I mean, if you know me, you know my work because it's high quality. But around here, people really care about credit. They really want the credit for the work because people think 'I am a good person' because I did that.[28]

[25] I was also part of the 33% of physicians who did not train in a VA facility.
[26] Interview with Staff Member #5, June 4, 2016
[27] Interview with Staff Member #11, August 10, 2016
[28] Interview with Staff Member #4, May 3, 2016

Understanding that the moral resources of the Department of Veterans Affairs is an organizational asset employees use to mark themselves as good is important for contextualizing the backdrop for the policy decisions that get made. It makes doing the work of the VA personal for employees. There is an honor that comes from working at the VA that self-affirming. This moral claim is further fortified by the fact that "health is of special moral importance because it contributes to the range of opportunities" available to people (Daniels 2008:2). This is one of many lessons I learned during my time at VA. I also learned that the cultural rules that govern health care systems in other settings, as chronicled by anthropologists, certainly applied to work at the VA but took on new forms (Kleinman 1980). I had to learn how to navigate a new social world that was part and parcel of working in government at the cabinet level. The stability of this new world was constantly shifting under my feet. For example, I had to learn to make sense of the ways in which meeting times were conspicuously changed five minutes before I would arrive at the office when specific senior leaders were involved. Having come from a world of academic medicine in elite institutions I was not unfamiliar with being excluded, but this was the first time in my professional life where I experienced what felt like a systematic attempt to exclude me from scheduled meetings. What did this mean? As the only female member of a six-person strategy team in the Office of the Secretary, experiencing repeated incidents of exclusions from meetings left me wary. But with time, I began to see an overall pattern about the way exclusion operated in that particular setting. I came to see it was about withholding recognition and signaling who belonged and who didn't when it came to the opportunity to contribute to policy.

First Encounter with the Competition to Give: Mental Health Summit

One of the first assignments I received as a White House Fellow was to help with the "first ever" VA/DOD Mental Health Summit and eventually participate in the expert panel that would write-up the recommendation for the Secretary of the VA and the Secretary of DoD. I was incredibly excited to be given an opportunity to learn more about mental health issues because as a primary care provider I had long realized that the pathway to a healthy body was a healthy mind. I was also excited to be a part of a "first ever" gathering that could help push the needle on a particular thorny issue: veterans' mental health.

As preparation for the summit was underway, the wars in Afghanistan and Iraq had become America's longest engagement in battle with an all-volunteer force. Less than one percent of Americans enlist in service which means the duration and frequency of deployments have increased over time to sustain engagement in a longstanding conflict (White House 2011). This means there is a disproportionate burden placed on those who enlist and as a result mental illness has been on the rise (Taennalian and Rand 2008). According to a study by Hoge et al., 19.1 % of troops returning from Iraq reported mental health problems, 11.3% of those returning from Afghanistan, and 8.5 % from other deployment sites (2006: 1027). In this study, mental health problems included depression, PTSD, combat stress reaction, and/or referral for a family adjustment problem. Underpinning this reality was the fact that human beings had limits that war not only tested but broke. And for the first time ever, the military was beginning to acknowledge it. "This issue--suicides--is perhaps the most frustrating challenge that I've come across

since becoming Secretary of Defense," said former Secretary of Defense Leon Panetta (DOD 2012).

The issue of suicides among members of the military was getting a great deal of press attention. Time magazine ran a cover story on the issue that sounded alarms.

> The U.S. military seldom meets an enemy it cannot target, cannot crush, cannot put a fence around or drive a tank across. But it has not been able to defeat or contain the epidemic of **suicides** among its troops, even as the **wars** wind down and the evidence mounts that the problem has become dire. While veterans account for about 10% of all U.S. adults, they account for 20% of U.S. **suicides**. Well trained, highly disciplined, bonded to their comrades, soldiers used to be less likely than civilians to kill themselves--but not anymore (Thompson and Gibson, 2012).

For many, the cause of the high rates of suicide was untreated mental health problems. To help address this unmet need, VA and DOD convened an unprecedented forum to attempt to mobilize every federal, state, and community asset to "to make sure everyone who fought for this country gets a fighting chance for a sound mind and an independent life" (VA 2009). The title for the joint VA/DOD summit was America's 21st Century Response to the Psychological Needs of Returning Service Members, Veterans and Families. The goal was to address the mental health care needs of America's military personnel, families and veterans, harnessing the programs, resources and expertise of both departments to deal with the aftermath of the battlefield. The planning for the VA-DoD Mental Health summit was well underway when I showed up. The VHA mental health team had put together an impressive conference program and were in the process of finalizing details. The lead for the team was a distinguished Professor from an institution that I had recently left and I had assumed that would serve as a point of connection that I could use to build a relationship. I was mistaken. From the very first

meeting I had with him – he was hostile and I really did not understand why. For the purpose of discussion, I will name him John. John was going to soon leave his position at the VA and he wanted his final time there to count.

The VA leader that had staffed me on this project pulled me aside to let me know he was very worried because the level of scrutiny on this particular issue was very high. He re-iterated several times that VA had to get this one right. There was a moral weight to this issue that was very heavy because the potential to do right was so great. The weight of what he was describing was correlated to the great deal of attention the issue had received in the press. I promised this particular leader that I would do my best to support the team.

My first meeting with the team organizing the mental health summit, and this particular individual, was fairly uneventful. It was a small team and I was hopeful that would make it easier for me to integrate myself into their workflow. I introduced myself, told them that the Deputy Secretary had assigned me to this project, and that I was here to help and learn from them. Of the three members of the team, one was cordial right away, the other two were more guarded. I didn't make anything of it at the time and chalked it up to them needing some time to get comfortable with me entering their working group. For the rest of the meeting, I just listened and took notes. I had a lot to learn about mental health issues among veterans and I felt very privileged to be sitting in the room with three nationally recognized leaders in the field, so all I was concerned with at the time was soaking in as much knowledge as I could. During the meeting, two members of the team made an effort to acknowledge my presence, but John did not. I really wasn't bothered and would not have noticed it were it not for how the meeting ended. As we all got up to

leave, I was the last person to walk out of the room. As I approached the door, he was standing waiting for me. The other two members had already left. With a naivete, that makes me laugh in retrospect, I said: "I am really looking forward to working with you." In response, he asked: "So is this a stepping stone into academia or out of it?" I was so caught off-guard by the question and his flat affect that I stumbled on my words. I told him that I was actually very interested in government service and hurriedly moved past him to get to the elevator. It was an awkward exchange, to say the least. I didn't understand it at the time, but it would be the first of many interactions during my time at the VA that felt unexpectedly aggressive. When I got back to my office, I immediately scribbled down his question to me in my notebook and circled it. There was something important there though I could not describe what at the time. His question was the first instance of someone describing the VA as a gateway to other professional opportunities.

I will return to this idea later but for now the important point is that one of the many things that the VA does, in addition to allowing people to mark themselves morally, is shape/influence professional careers. Time spent working at the VA, particularly central office, is used as leverage to attain and secure professional advancement long after people have stopped working there. The other members of the mental health team I was working with had all distinguished themselves by working in the field and publishing on the issue of mental health before coming to headquarters office. They all had relatively well-known professional reputations and were "stars" in the field. Their time in central office solidified this positioning even more. (So to fully understand the VA and what it does, you must also consider what it is that people who have worked there go on to do). These realizations came years after the initial exchange I

had with John, which at the time had left me flustered. The important point is that this particular senior leader was very aware of the potential impact the VA could have on my career, even if I was not, and he made a pointed effort that almost felt like he was policing this possibility. Did I deserve to be there?

As the mental health summit got closer, my meetings with the mental health team became more frequent and I began to get more involved. I did not let John's awkwardly aggressive questions get in the way of having a fruitful learning experience. But excerpts from my early notes document that his aggression continued. On Tuesday, October 6, 2009, I wrote:

> In preparing for the mental health prep meeting and the whole new cast of characters I will meet, I am realizing that passive aggressive behavior is more the norm than not. I can't help but feel like the nature of this is rooted in defensiveness all around but am not sure what they are defending. Turf maybe? But that seems silly given we are all working towards the same goal. Aren't we? But I am starting to feel like it is becoming almost impossible to not step on people's toes. In any case, the only time I have gotten emails back from John have been articles he sends me. Otherwise he just doesn't respond. Even when I ask him basic questions about things he has asked me to follow up on which to me is the most extreme form of passive aggressive behavior.

John ignored me throughout the process of preparing for the mental health summit. After a while it started to irritate me. Things came to a head in one of the prep meetings when some of the staff who wanted me to play a role in helping write the report and participate in the communications efforts around the meeting forced John to directly engage with me. His response to their suggestion that I speak in one of the communications events was: "It would not be foolish to have her speak." He formed his response by framing it as

a negative. In other words, it was easier to contemplate my involvement by what it was not, then what it was. These kinds of backhanded compliments reflect an unhealthy amount of skepticism that permeated the environment at the VA.

As the mental health summit approached I had other passive aggressive encounters with John that forced me to finally ask him why he was being so aggressive with me. On Tuesday, October 20, 2009 I wrote:

> I am actually remembering that in our one to one, John and I that is, he tried to get me to explain why I perceived him as unwelcoming and I told him that I thought him and Anna had a great deal of control and didn't know how to share it. Then he mouthed back: "we have no control" and it dawned on me then that he was operating in a bit of a black box.

When John said he had no control, I learned that what he meant was he had no control over what happened in his part of the VA – the Veterans Health Administration (VHA). VHA was located on the 8th floor in the headquarters office and was run by the Under Secretary for Health. I would have my own interactions with the Under Secretary which would soon explain why John had little control – but I had not had those experiences yet.

VHA is America's largest integrated health care system. With a medical care budget of more than $53 billion, VHA employs over 272,000 staff members, at more than 1700 sites including hospitals clinics, nursing homes, domiciliaries,[29] and Readjustment Counseling Centers (VHA 2012). Within the bureaucracy of VHA, John led the Office of

[29] The Domiciliary Care Program is the Department of Veterans Affairs' (VA) oldest health care program. Established through legislation passed in the late 1860s, the Domiciliary purpose was to provide a hoe for disabled volunteer soldiers of the Civil War. Currently the Domiciliary Care program is a long-term rehabilitation program which provides veterans a chance to live in the community while learning skills and avoiding a return to homelessness.

Mental Health Services (OMHS) which was the national program office that set program and policy guidance for mental health services provided throughout VHA. The Office of Mental Health Services is a component of Patient Care Services (PCS) with indirect connections to services at the VA Medical Centers and Clinics. OMHS oversaw an expansive set of programs and services (see Appendix A) but within the larger organization it was still relegated secondary, structurally, to PCS.

After John shared his thoughts about a lack of control, I started to spend more time with the leadership in VHA to see if I could unpack what he meant. It didn't take very long for me to understand that John's passive aggressive leadership style was not an exception in VHA – it was the norm. During my first meeting with the doctor that led a very large program within VHA, Susan, she was cordial but hard to read. On September 24, 2009, I wrote:

> Susan seems like a no-nonsense type of person but she has a poker face that is hard to penetrate. She leads VHA's largest health program office center and has built it into an empire of over 10,000 employees. She's a powerful figure in the bureaucracy and I think she knows it. Maybe that's why she kind of put me on the spot during the mental health prep meeting today. Was not ready for her challenge. When Andrew suggested I help write the report. She looked at me with a blank stare and suggested another name would be better suited.

My future interactions with Susan were similar. It was almost like I wasn't there. On Monday, March 8, 2010 I wrote:

> Susan's refusal to recognize me in meetings is fascinating. The only time she almost does is if the Secretary is around. I am fascinated because it's so consistent and by that I mean every interaction I have with her is almost exactly the same. A cordial greeting, withheld affect, extremely

> speculative gaze, and an avoidance to acknowledge almost anything I say. I have been asking around about her. Everyone says she has been very effective at expanding the terrain of the reach of her program. She has established an almost ceaseless number of programs under her watch and supported the advancement of countless careers throughout VHA. She has figured out how to make the bureaucracy replicate effectively and use it to advance the people she supports.

The similarities between John and Susan's passive aggression lie in the ways they both withheld any form of recognition when I was in meetings. There was a spectrum to this form of withholding and I learned that John and Susan were far from the extreme end. There were other VA leaders I would encounter who were far worse in this respect. For example, one senior leader, named Michael, would regularly cancel meetings with me simply to show me he was the one who could. These meetings were never scheduled by him, they were always the result of a member of the Strategy team advising me to keep this particular person abreast of what I was doing. The first time I tried to do this he had me wait in front of his office for an hour while he stayed inside working in front of the computer. I asked the secretary if I should reschedule and she politely told me he would be right with me. At the time, my aunt was undergoing chemotherapy for ovarian cancer, and on that particular day I was supposed to go to the hospital to check in with her. I was already feeling bad about having to leave from work early so after an hour I decided it would be better off to reschedule and head to the hospital. I went up to his secretary and told her that I had a family emergency and left. The meeting was rescheduled for 8am in the morning the following week. When the time came for this meeting, I arrived to my office at 7:45 A.M. with my notes for my meeting. I was commuting to Washington, DC by metro from Alexandria, Virginia which was about 45

minutes door-to-door and mostly underground. So anyone who tried to call me or email me during my commute in would never reach me. When I walked over to Michael's secretary for my meeting, she looked embarrassed. I asked her what was wrong because she appeared flustered. She apologized before letting me know that Michael had changed the time for our meeting that morning to 7:30am and that she had tried to reach me over email. I couldn't believe it and I didn't know what to say. I think that is when I really began to understand that withholding of recognition in the VA was about power.

I went back to my office slightly dejected. On my way back, the leader who had suggested I meet with Michael in the first place could see the confusion on my face but said nothing. The only words he could muster up was, "you should probably get here earlier." I said nothing and tried to go about my day. The Mental Health Summit was fast approaching and there were things to get done. I dove into the details and welcomed the distraction. The week-long conference agenda was very ambitious and the speakers we had invited were all considered leaders in the field in one regard or another. In addition to mental health experts, participants in the Summit included representatives from other Federal agencies, advocacy and service organizations (Veterans Support Organizations (VSOs), Military Support Organizations (MSOs), and non-profit organizations, national experts from academic institutions and the community, with a total number of attendees that was expected to be well over 300. These invited presentations and discussions included a broad spectrum of pertinent topics focused on current programs, gaps, and opportunities for enhancement; stakeholder perspectives; prevention, wellness, and resilience; use of new technologies; involving families and communities in mental health; and ways to demystify mental illness and overcome the stigma associated with seeking

mental health care. I asked if the public was going to be able to attend the conference and was surprised to learn they were not.

The compromise was the first day of the meeting was "open", the subsequent few days were a closed technical working group. At the end of the Summit, a 12-member VA/DOD Expert Panel would write a report summarizing policies, programs, and practices that show promise for enhancing care for Service members, veterans and their families. I was placed on the Expert Panel by the Deputy Secretary. There were six members from VA that were appointed to the panel and six members from DoD. I did not have any visibility into how the other people were assigned to the panel but I could tell that my being on the committee had ruffled some feathers. In preparation for the summit, there were several meetings with our DoD counterparts where this became apparent. During these meetings and on more than one occasion I was asked how I got on the panel. By the third time I was asked the question, I understood that what I had taken for granted as part of my time as a White House Fellow, was what others viewed as a prized position. The first two times I got asked the question, people did not disguise their disdain. The third time was less obvious. A woman who had befriended me from DoD was expressing enthusiasm about her hopes for the Summit. She was someone I had identified as clearly committed to the issues of service members and veterans and at least up until that point, a friendly straight shooter. The first day of the conference, I ran into her right before the proceedings were going to begin and she asked: "So how did you get on the panel anyway?" For the first time, she wasn't smiling. I told her the Deputy Secretary had assigned me and hurriedly moved to find my seat. Her question was similar in pitch to John's prior attempt to police my participation. In both instances, the issue was

whether or not I deserved to be participating. And perhaps to put a finer point on it what I had done to deserve the chance.

The interactions I have described thus far share a common feature that I would describe as inappropriately aggressive for the workplace, at least from what I was used to as normal conduct in the workplace. There was also an intensity to the interactions and perhaps an underlying suspicion that seemed to be signaling that limits should be placed on the extent of my participation. I experienced attempts to police my participation as instances in which I was being intensely evaluated. Though I could not specify the exact criteria against which I was being judged, it was clear that making policy in headquarters was a privileged space for the honorable – those who had earned the respect of their peers in the field. By that standard, I didn't fit. Regardless, because of how high I sat in the organizational structure of the VA, and the fact that the Deputy Secretary was the one that involved me in the planning of the Summit and the Expert Panel, there was little room for anyone inquiring to take their objections any further. But one can imagine that in a universe where I did not come with high standing backing, these aggressive probes could easily become challenges with consequences.

The process of participating in the Expert Panel was more of the same. This time, two of the VA leaders in particular made it very clear that my contributions to the report would be limited to edits - not actually prose. Again, I was fine with it, because I was new in the job and eager to learn so I viewed the opportunity to edit the report as a meaningful contribution. Everyone else got to contribute to the prose of the report. I was quite happy editing other peoples' words because I was much more interested in what would happen after the report. Presumably, others were too but I started to doubt this as I

began to edit the report. Interestingly, one thing that immediately struck me as I was reading the recommendations was that they could have been written without the meeting. In other words, there was nothing new that came out of the meeting. The report was essentially a summary of the scientific work that scholars had published already or presented. So what was the point of making such a big effort in a "first ever" meeting if there were no new ideas that were going to come out of it?

I naively posed this question to a colleague at the VA and she explained that a collective effort to improve mental health at the VA and DOD was already under way as part of the Integrated Mental Health Strategy (IMHS). The Senior Oversight Committee (SOC), chaired by the DoD and VA Deputy Secretaries, initiated the requirement for developing the IMHS. This was a process that was already well underway by the time the planning of the joint mental health summit had begun. Although both DoD and VA had separate programs to address mental health issues, the IMHS is focused on issues that were common to the two Departments. This effort had identified 28 joint actions to address the needs of servicemembers, veterans and their families and the recommendations from the 2009 VA-DoD Mental Health Summit was fed into this process. A staff interview with a psychological health leader within VHA explained: "The IHMS is an actionable way to make sure the recommendations from the summit are funded."[30] I asked her if the point was to take action or to try and do something different. She responded that for a long time the VA and DoD did nothing in the face of extraordinary unmet mental health needs so that something was better than nothing.

[30] Interview with Staff Member #11, August 10, 2016.

What I know now is that the VA/DOD Mental Health Summit was more of a symbolic gesture than it was an effort to affect change. The recommendations from the Summit were fed into a pre-existing process for improving mental health care that pre-dated the Summit. Effectively the Summit was a formality to signal to the public and the press that VA and DOD were going to work together on this issue even though in reality the institutions efforts to collaborate were sorely hampered by a variety of reasons that included an unwillingness from staff as well as institutional cultural differences. A critical difference was the fact that mental health issues from the perspective of DOD was about force readiness and for the VA it was about doing what was right for veterans. The Secretary often made the statement that the DOD created the VA's workload and often its problems. Mental health was perhaps the clearest expression of this tension – admitting that war can break people makes it difficult to recruit soldiers and retain them. So whose interests does it serve to hold a summit that essentially checks a box?

By the time, the Mental Health Summit was over, I had observed several peculiarly aggressive incidents that revolved around setting boundaries to my participation and what it made me very aware of was that I was constantly being evaluated. Years later, I began to understand that this was part of a larger pattern I would observe over the course of my study. I would sum up this observation as: health policy formation at the VA is an intense site of competition. More specifically, health policy formation at the VA is defined by agonistic giving where the opportunity to freely exchange ideas and contribute to policy depends upon whether institutional actors confer or withhold recognition. Whether or not institutional actors confer recognition is related to abiding by the cultural rules that govern reality in the institution. For example, there

are rules about whose Power Point slides go before the Secretary and whether or not you receive an attribution for any "thought work" you do on slides as author. A misstep in abiding by such rules makes it less likely for you to be recognized by institutional actors and therefore less likely to be able to make meaningful contributions to policy. I witnessed an incident in the lead up to the Mental Health summit that made this very clear. An excerpt from my journal captures this incident and my reaction to it:

> I have never seen someone so angry at the format of a presentation. Glad he wasn't ranting about me. Apparently the format of the mental health brief was totally not appropriate. Who knew? I thought it was ok. But there is actually a script to these things… military briefs that is… no one ever told me that before. His response was given at a volume and in a manner that completely negated the validity of everything that was included in the brief meaning. The format dictated whether or not the brief was good. It kind of caught me off guard. I have noticed that when him and I are in total conflict, I tend to get extra quiet because I don't want to follow him where he is taking it. But more importantly because going head to head with him is not my goal. It's a no-win situation. As Jason[31] pointed out in the lunch we had, he's a guy who is used to being in charge. And the things he is not in charge of he pays little attention to.
>
> That said, he ranted and raved that he had taken his eye off of this and implied that that was a mistake. I think mid-rant and with others in the room he realized that he was talking to me and it could mean that I was now being faulted. So he back stepped and said that of course I was the content expert on this but that the person presenting should have been better about the brief. He's a war college guy and they have better knowledge on this stuff than anyone else. I just listened because I felt bad for the presenter. The truth is his presentation style couldn't be worse for the receiving team. He knows his stuff but he clearly doesn't have the script on what is expected with respect to format.

This was the first time I realized that the way you present information in the VA matters greatly. There is a style to the practice of governance that matters if you want to be heard.

All these observations about passive aggressive encounters or outright hostile behaviors share one thing in common: it makes it difficult to contribute to the process of policy formation without making the work personal. Yet technocrats and bureaucrats at the VA pride themselves at always keeping veterans at the center of the work. So how do these two seemingly opposing ideas co-exist? The answer lies in the tight ways in which VA allies technocrats and bureaucrats so that their combined influence on policy becomes a form of administrative power that is particularly difficult to penetrate. What this means with respect to policy is that often its formative process is closed - difficult to shape.

This case study also illustrates/reveals that the presentation of ideas in the policy arena has similar dynamics to what Mauss describes (1990 [1950]). In this setting, analogous to the scientific contributions that are made by academics to the literature, the experts at the VA make contributions in the policy arena that I argue can be viewed as Maussian gifts in the sense that, the presentation of ideas about improving mental health issues for active duty service members and veterans and the institutional conditions made "the thing received…disclaimed and mistrusted" (Mauss 1990: 22). The effects of this competitive exchange in the context of a policy arena that has been highly politicized reveals what can happen when honor is tightly connected to politics. This builds on Charles Taylor's description of "the honor ethic" which confers dignity to those who play a role in public life, such as civil servants, and "the fierce competition for this kind of dignity" as being "part of what animates democratic politics" (Taylor 1989: 25).

Agent Orange Presumptive Policy: The Collision Of Statutory Standards And Scientific Causality

Veterans that are injured during military service or develop an illness that is a long-term consequence of their service are entitled to receive healthcare coverage and disability compensation by the VA. The latter, disability compensation, is paid out by the Veterans Benefits Administration (VBA) which the VA oversees. These payments are meant to replace the average earnings lost as a result of service-connected disabilities. These payments are not contingent on other income, meaning veterans who are gainfully employed can still receive these benefits.

The VA provides disability compensation to approximately 4.5 million veterans that costs over $64 billion annually (CBO 2014). This expenditure has more than tripled since 2000 when it was $20 billion (CBO 2014). The rising costs of compensation are partly due to the recent veterans who are withstanding injuries due to advancements in medical science that would have led to death in prior wars. Though Iraq and Afghanistan veterans accounted for 10% of the veteran population, they make up 17% of those receiving disability benefits (CBO 2014).

In order for a veteran to claim disability compensation, he/she must prove their disability is service connected. This means the veteran must prove that an illness or injury occurred as a result of an exposure or event during military service *and* that this exposure or event led to the illness or injury. In other words, individuals must make the case for a causal link between an exposure or event and their illness. Causation is easier to determine for some injuries compared to others. For example, in cases where veterans were injured by bombs or gunfire, the physical wounds that often lead to amputations are

clearly service-connected. But how does one make the case for causality in situations like PTSD? Or how does one make the cause for causality when the exposure is something like Agent Orange and the science has yet to determine the list of potential long-term illnesses associated with the exposure? Both of these questions confront the limitations and uncertainties that making health policy at the VA must negotiate in setting policy. In particular, the power that the VA has to create presumption of service-connection draws these tensions into sharp relief.

Presumptions are a special category of policy in the VA's bureaucracy where the normal requirements of establishing proof are foregone in an effort to simplify the process for receiving compensation. Presumptions relieve veterans of the burden to prove that their disability or illness was caused by a specific exposure that occurred during military service (IOM 2008). More technically, a presumption is a legal inference, a rule of law.

> Generally, a legal presumption is a procedural device that shifts the burden of proof by attaching certain consequences to the establishment of certain basic evidentiary facts. When the party invoking a presumption establishes the basic fact(s) giving rise to the presumption, the burden of proof shifts to the other party to prove nonexistence of the presumed fact. A presumption, as used in the law of evidence, is a direction that if fact A (e.g., manifestation within the specified period of a disease for which a presumption of service connection is available) is established, then fact B (service connection) may be taken as established, even where there is no specific evidence proving fact B (i.e., no medical evidence of a connection between the veteran's disease and the veteran's military service) (VA 1993: ii).

The history of presumptions date back to 1921 when amendments were made to the War Risk Insurance Act to allow for veterans with tuberculosis and psychosis to

receive VA benefits. Of note, up until the late 1970s all presumptions had a specified time period in which the disease had to have manifested itself which was up to one year after separation from service. There are many reasons that justify the use of presumptions in the VA. First and foremost, in many cases, information about exposures were simply not collected at the time because it preceded the science. For example, in cases of chemical exposures in the field that were not known to be harmful at the time. This makes it impossible for a veteran to make a causal case that their illness was connected to exposure. Secondly, presumptions can help ensure that similar claims get dealt with consistently across the board. The discretion that bureaucrats have in making determinations about what counts regarding service connection invariably differs which means the approval of claims can be uneven (Lipsky 1980). Presumptions can help eliminate this problem. Thirdly, "presumption may implement policy judgements that the burdens arising in certain cases be borne by the Government rather than the veteran claimants" (Zeglin 2006: 3). Shifting the burden to prove causality to the government rather than veterans is the justification for the use of presumptions that informed the decision to create new presumption Agent Orange service connection categories under Secretary Shinseki. I will discuss this decision-making process that arrived to these new categories of service connection further below.

In order for a disease to become a presumptive disability, many different stakeholders that include Congress, VA, the National Academies, Veteran Service Organizations and veterans all play a role as show in Figure 6.

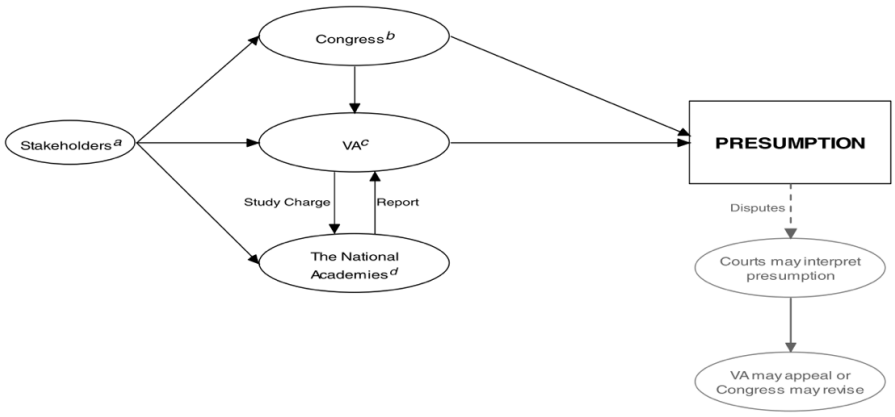

Figure 6, Stakeholders Involved in the Presumptive Disability Decision-Making Process for Veterans (IOM 2008)

The current decision-making process for determining presumption was put into place by the Agent Orange Act of 1991. This legislation established a presumption of service connection for Vietnam Veterans who were exposed to Agent Orange and other herbicides. The act requires the VA to contract with the Institute of Medicine (IOM) to review the scientific literature, every two years, linking herbicide exposure to medical illnesses. This means that since 1991, the IOM, at the request of the Secretary of Veterans Affairs (VA), has conducted biennial, comprehensive evaluations of the scientific and medical information regarding the health effects of exposure to Agent Orange and other herbicides used in Vietnam. The basic charge to the IOM is to evaluate whether there is a statistically significant increased risk of disease among those exposed to herbicides in Vietnam, and whether there is a plausible biological mechanism or other evidence of a causal relationship between herbicide exposure and the disease. In the 2008 update to the IOM report that VA was reviewing, B cell leukemias, Parkinson's, and ischemic heart

disease (IHD) had all been added as conditions associated with Agent Orange exposure. As part of the process, VA had to thoroughly review this report and determine whether or not a new presumption was in order based on the scientific findings. Upon review, if new studies linked Agent Orange to illness which were hitherto not associated, then the Secretary of the VA had authority to create new presumptions.

I was part of the group that reviewed the report and was tasked to compile everyone's thoughts from VHA and OSVA in order to send recommendations to the Secretary. The VA staff involved in this process read through the studies that were cited in the IOM report and were asked to weigh in with their interpretation. Interestingly, there was a divide between VHA and OSVA with respect to the association of herbicides and heart disease despite the objective findings in the report which included five studies that showed strong statistically significant associations between exposure to herbicides and development of heart disease. OSVA staff supported the creation of a new presumption for heart disease while VHA did not. The disagreement was related to the relatively common prevalence of heart disease in the aging American population. Staff in VHA felt that heart disease was far too common in the general population to attribute Agent Orange as a veritable cause. In a testimony to Congress[32] the Secretary explain explained that "presumptions are used to implement policy when scientific certainty cannot be achieved in a time frame necessary to address veterans' healthcare issues." He went on to say that:

> The Agent Orange Act was a compromise between the desire for scientific certainty and the need to address the legitimate health concerns of veterans exposed to herbicides in service. By establishing an evidentiary threshold

[32] https://www.va.gov/OCA/testimony/svac/09232010SecVA.asp). Accessed December 10, 2018.

> lower than certain and lower than actual causation, Congress required that presumptions will be established when there is sound scientific evidence, though not conclusive, establishing a positive association.

Association, not causation, was the standard the law used to compel the Secretary to create a new presumptive eligibility. This is a different evidentiary standard than the one used in the scientific literature to determine whether Agent Orange causes ischemic heart disease (IHD). The difference in the standards came to a head when the Secretary released his ruling. The ruling stated that:

> …an amendment is necessary to implement the decision of the Secretary of Veterans Affairs that there is a positive association between exposure to certain herbicides and the subsequent development of hairy cell leukemia and other chronic B-cell leukemias, Parkinson's disease, and ischemic heart disease (Fed. Reg. 2010: 53202).

The VA received two letters from Congressman that were unlikely critics – Senator Daniel Akaka from Hawaii, the Chairman of the Senate Veterans Affairs Committee, and Senator Jim Webb from Virginia, a veteran himself who was one of VA's staunch supporters. These letters and VA's response to them represents the role expertise plays in relaying the work of government. Senator Webb and Senator Akaka were both very concerned by the cost of adding heart disease as a presumptive service-connected disability. The estimates of including IHD as a presumptive category were $13.6 billion during the first year, $25.3 billion for five years, and at least $42 billion over ten years.[33] The costs of the heart disease presumption represented 91% of the costs

[33] Staff interview #2, April 15, 2016

of the new presumptive disability categories. The letters from both Senator Webb and Senator Akaka stated that the magnitude of this decision required proper congressional review and oversight. A closer reading of these letters shows the ways in which expertise is mobilized to hold VA accountable.

The Webb letter was most specifically concerned with the fact that heart disease was far too common of a disease and stated that the "Agent Orange Act was originally conceived to establish presumption of service connection for relatively rare conditions with a positive association between exposure and disease" (Webb 2010). VA's response to Senator Webb's letter emphasized the legal standard stipulated in the Agent Orange Act of 1991. In that Act, Public Law 102-4, it states:

> Whenever the Secretary determines, on the basis of sound medical and scientific evidence, that a positive association exists between (A) the exposure of humans to an herbicide agent, and (B) the occurrence of a disease in humans, the Secretary shall prescribe regulations providing that a presumption of service connection is warranted for that disease for the purposes of this section (38 U.S.C §1116 (b)(1)).

The letter goes on to explain that absolute scientific certainty, in other words what conventional scientific reason would define as causality, is not the standard being used to assess presumption. Instead the law states:

> An association between the occurrence of a disease in humans and exposure to an herbicide agent shall be considered to be positive for the purposes of this section if the credible evidence for the association is equal to or outweighs the credible evidence against the association ((38 U.S.C §1116 (b)(3)).

The VA's response to Senator Webb points out that threshold set by an association that is "equal to or outweighs" effectively limits the discretion the Secretary has. The letter's explicit review of the statutory standard for credible evidence in Public Law 102-4 is notable for being a lower threshold than the scientific standard that determines causality. In this case the legal standard for statistical association was more important than causality.

The VA's response to Senator Akaka delved into even more technical details about the science underlying the presumptive ruling and the implementation of the rule. Senator Akaka's letter raised a number of very technical questions regarding the methodology and citations used to assess the prevalence of heart disease that was included in VA's ruling, the diagnostic tests VA will use to assess IHD with corresponding costs, the medical competency of VA practitioners tasked with diagnosing and treating IHD, etc. I was included in the chain of emails to draft a response to the letter and was struck by the number of revisions the letter went through as well as the ways in which experts mobilized both within the VA and outside of it to craft a response. Because of VA's tight affiliations with medical schools and centers across the country, it has an affiliated network of researchers and professors that it can call on to help the Secretary respond to issues as needed. These experts were mobilized to help respond to Senator Akaka's letter and provided helpful ways to buttress the Secretary's decision to create a presumption for heart disease. In particular, these experts pointed out that the studies showing a strong association were dose-dependent such that the greater the exposure to Agent Orange, the greater the occurrence of heart disease. In conventional scientific reasoning, dose-dependent relationships are considered further compelling

evidence for causality. These experts also pointed out Agent Orange's well-established target mechanism, blood vessel damage, as being a plausible mechanism for how IHD develops. The ways in which experts were used to respond to congressional demands for oversight shows how technical knowledge can be leveraged to meet political needs.

Senator Webb succeeded in placing a 60-day congressional review period as an oversight measure. When this period ended, the law was finalized and the VA began to grant service connection for IHD as a presumptive condition related to Agent Orange exposure. Soon after, a story about a veteran who had just been awarded retroactive payment based on the new presumption ruling came across my desk. The veteran had served in the Army in Vietnam from 1966 -1968 and received non-service connected disability pension for one year in the 1980s that totaled to $12,353. In 2010, this same veteran had filed a claim with the VA for service connection for prostate cancer and ischemic heart disease and was granted service connection for the cancer but the decision concerning service connection for IHD was deferred until the law regarding new presumptive conditions for Agent Orange had been finalized. In the time between the time that the law was being finalized and the 60-day congressional review period this particular veteran was scheduled for heart surgery. About one week before his surgery, the VA reviewed his case and awarded him retroactive payment compensation in the amount of $609,407. The payment was scheduled to be deposited into his savings account on the same day of his heart surgery.

The findings of this case study build on Adriana Petryna's work showing that although "at the level of the modern state, spheres of scientific production and politics are in a constant process of exchange and mutual stabilization" there are instances where

"stabilization proves to be a much more difficult task" (2002: 21). In this case study, the legal standard subsumed the gold standard of science, which meant the dominant mode of thinking about causality for this particular health issue was disrupted in the policy formation process. This reveals that expert systems have a more complicated relationship to the policy formation process then as conventionally understood. The hegemony that is often presumed can fall apart and make room for contestation.

Joining Forces: the case of military families

During the Obama administration, the care and support of military families became a top national security policy priority. In May 2010, the President directed the National Security Staff (NSS) to develop a coordinated approach to supporting military families that involved the entire federal government. The goal was to harness the resources and expertise across all departments in government to improve the quality of military family life and help civil society more effectively support military families (White House 2011). The logic driving this effort was partially about security concerns. President Obama explained that "stronger military families will strengthen the fabric of America" (White House 2011: i) and that more effectively supporting them improves the long-term effectiveness of the military force. The vision guiding the effort is summarized below:

- The U.S. military recruits and retains the highest-caliber volunteers to contribute to the Nation's defense and security;

- Service members can have strong family lives while maintaining the highest state of readiness;
- Civilian family members can live fulfilling lives while supporting their service member(s); and
- The Unite States should better understand and appreciates the experience, strength, and commitment to service of our military families (White House 2011:2-3).

This policy process was spearheaded by the NSS staff who convened an Interagency Policy Committee (IPC) comprised of representatives from the staffs of all Cabinet Secretaries using a very specific mechanism – a Presidential Study Directive (PSD). PSDs are commissioned at the discretion of the President and represent a form of executive power that is not readily accessible for scrutiny. Under the terms of the PSD, the IPC had 90 days to complete the following:

- Set Strategic military family priorities for the next 10 years and identify key military family concerns and challenges;
- Review a cross section of public and private programs that could positively impact military families in order to identify the most promising research-based programs that produce results;
- Develop options for departments to integrate military family matters into their strategic and budgetary priorities;
- Examine opportunities for Federal policies and programs to stimulate existing state and local efforts achieving military family readiness goals and meet military family priorities;

- Identify opportunities to leverage more of the skills, experience, and capacity of military family members in national and community life;
- Strengthen existing feedback mechanisms for military families to voice their concerns and opinions, their unique challenges on the effectiveness and future direction of related Federal programs and policies; and
- Highlight military families' contributions to national and community life.

In order to complete this comprehensive review, the IPC divided its work into four sub-committees that had different foci: psychological health, spousal employment, education of military children, and child care. These four priority areas of concern were developed with input from the National Economic Council, Office of the First Lady, and the Office of Dr. Biden and had further sub-objectives (see Appendix B). I participated in the IPC as part of my time as a White House Fellow and, more specifically, I was co-chair of the sub-IPC committee for psychological health – arguably the broadest given the objectives listed in Appendix B. This committee met weekly for 90-days and my primary task in these meetings along with my co-chair who was a senior leader at the Substance Abuse and Mental Health Administration within the Department of Health and Human Services (HHS) was to help synthesize the scientific literature on mental health and translate it to committee members who were non-health experts. This was a massive exercise in translation and it was largely done through documents and diagrams, some of which I have included as primary data in the appendices (see Appendix C-H).

Two colleagues from the VA also sat on this sub-committee with me. Once a week, every Friday, we would meet in various locations in the government to discuss

psychological health issues and pool our mental resources together to see what could be done. I loved these meetings because they were incredibly productive, unlike other meetings I had to attend. The NSS lead, driving the entire IPC process, Oscar, was incredibly committed, earnest, and willing to learn as much as he could about mental health issues. He was a veteran himself and I found my conversations with him to be pleasant, efficient, and straight forward. When I referred him to helpful articles, he always read them and had an insight to share by the next meeting. We eventually built a relationship of trust and developed a rapport as colleagues. A great deal of the bonding was the result of spending hours in meetings trying to understand what the science said about preventing and treatment mental health issues among veterans and service members and doing something with this information.

We synthesized our understanding into power points, diagrams, and other documents. These documents were carefully constructed products that reflected a collective understanding of the material we had worked hard to attain. A closer look at these documents reveals the thought work performed by the IPC which positioned mental health status on a continuum alongside mental health care (see Appendix D). The diagram included in Appendix D guided a great deal of the thinking and positions mental health status and mental health care as having positive components. Instead of a deficit model of mental health care, the IPC used an expanding definition of mental health care that takes into account well-being and what can be done to strengthen it. These discussions about the positive framing of mental health status sought to better understand what could be done to increase the individual capacity of military members and their families. This effort was focused on redefining mental health treatment as an issue of

prevention in the hopes of treating the military family before mental illness begins. A primary document in the historical archive I have accrued from this work describes the strategic objective of this redefinition as being to "maintain behavior health of military and veterans' families as or above the national norm" (see Appendix E).

To better flesh out this idea the IPC created more diagrams (see Appendix F - Appendix H). These diagrams attempted to capture a snapshot of what a resilience-oriented system of care could look like. In this system, the spectrum of services strengthen the behavioral health of military families as a measure of prevention. This was quite a different version of mental health care than existed. The current system existed on the far-right end of the spectrum of Appendix F. Thus drawing these diagrams was an exercise in imagining the future.

It is within the context of imagining the future that culture as a thing, more specifically, military culture, entered our discussions. In the distributed meeting notes from the IPC where culture was raised, this idea is articulated as:

> Improve comfort level and familiarity of mental health care providers with military culture and increase focus on non-skilled and semi-skilled support services. Assist Military and Veteran families in changing their perception of the mental health provider community (both skilled and non-skilled).[34]

Singling out military cultural competency within a larger discussion of expanding definitions of mental health care is notable because culture was raised as an important variable to consider in establishing a resilience-oriented system of care. Raising the

[34] Primary document. Sub-IPC May 2, 2010 minutes.

importance of culture in this policy context provokes the question: does having a culturally sensitive mental health care provider lead to improved behavioral health? There was no data to support that it does. Nonetheless members of the IPC felt it was important to suggest mental health care providers became versed in military culture. This was not the first time a policy recommendation was made on little to no data.

When it came time for me to present the work plan for our sub-committee to the larger IPC committee, the diagrams proved to be critical tool in communicating our ideas. At the meeting where we presented these ideas we handed out the diagrams and invited the members to imagine what metal health care could look like. Our presentation was well received and Oscar was quite pleased with our work. He recognized me in front of the larger IPC group and shared some kind words about my contributions. After the meeting, one of my VA colleagues seemed less than pleased that I had received some recognition. Through a forced smile she told me I was going a "great" job and that Oscar was a "great" guy. I thanked her and then she proceeded to tell me a story about a job she was up for on the NSC but did not get. It turns out she was a military spouse herself so the IPC work was very personal. The job she had wanted was to be the policy lead on military family issues on the National Security Council. She was complaining to me that that person they chose to hire had expert knowledge about the material but no lived experience. The timing of her sharing this story, right after I had been recognized for my own expertise on behavioral health, was not lost on me. It felt like she was trying to tell me that working on military family policy issues as an expert was different than having lived experience and working on the policy issues. She was making it a competition. I didn't engage. I just listened and told her that the contributions she was making to the

IPC would undoubtedly have an impact. I ended the conversation on that point and hurriedly made my way back to the VA – alone.

At the end of the 90-day period, the weekly meetings stopped, and I continued my work at the VA. About a month later, the same VA colleague who had been passive aggressive went out of her way to share some personal news about Oscar and told me I should drop him a note to check in. I said I would and then she mentioned something very specific. She told me to address my email to him by his military nickname, which I was not privy to. In retrospect, the specificity of her suggestion should have given me pause. But my professional respect for him overshadowed any hesitation. I hurriedly fired off a "check-in" email and went about my day. I never heard from him again.

Months later, I was in a meeting for a non-profit organization that was working with veterans on re-integration issues and supporting military families. Oscar was at this meeting. I hurriedly went over to him to say hello. He was stiff, formal, and distant -- nothing like what I remembered him to be. I couldn't figure out why. When I got back to the office that day I pulled up the last email I had sent and combed it for clues. His nickname was the first thing that stood out. Why had I used that? It no longer seemed appropriate to use. It seemed too informal in the context of a work setting.

It dawned on me, only in retrospect, that my VA colleague's very specific suggestion to send that email may be the reason that I never heard from him again. It felt like this particular VA colleague had sabotaged my working relationship with Oscar on purpose. At the time, I didn't have the faintest idea why. But in retrospect, I think it was because Oscar had recognized me and in so doing validated my own connection to the

issues, even though I had no lived experience. Interestingly, the VA colleague who did not want me to work on military family issues did not last long at the VA. She ended up leaving her position for undisclosed reasons. When I inquired into why she had left, I was told by VA staff that she was still "searching" professionally and the VA was not really a good fit.

The observations about the competition my colleague had presented to me is about who is allowed to contribute to the policy process and builds on the observations from the first case study. In the policy arena, an individual's ability to contribute meaningfully to policy formation is often limited by the recognition that a person does or does not receive. The policy literature rarely mentions the personal identity issues that can bear on the policy formation process. Despite people who may police participation by having recognition restricted or withheld does not preclude making an impact.

Drawing on the findings of PSD-9 in 2011, First Lady Michelle Obama and Dr. Jill Biden launched Joining Forces, "a nationwide initiative calling all Americans to rally around service members, veterans, and their families and support them through wellness, education, and employment opportunities".[35] This initiative engaged both the public and private sector in and leveraged the weight of the federal government to direct actions in civil society at an unprecedented scale. The primary objectives of Joining Forces was to:

- Bring attention to the unique experiences and strengths of America service members, veterans, and their families
- Inspire, educate, and spark action from all sectors of society – citizens,

[35] www.joiningforces.gov. Accessed August 20, 2018.

communities, businesses, nonprofits, faith-based institutions, philanthropic organizations, and government – to ensure service members, veterans and their families have the opportunities, resources, and support they have earned

- Showcase the skills, experience, and dedication of America's service members, veterans and their families to strengthen our nation's communities
- Create greater connections between the American public and military [36]

As a part of Joining Forces, in August of 2011, President Obama challenged the private sector to hire 100,000 veterans and military spouses. By the 5th anniversary of this effort, the list of private sector companies who had committed to hiring veterans and military spouses led to more than 1.2 million veterans and spouses gaining employment or training as a result of Joining Forces. This is a remarkable statistic given the fact that at the beginning of this effort veterans unemployment was at 12% and had decreased to below the national average within the five years that this program had begun. This impact instructs the far-reaching effects that the federal government can have on influencing the private sector. But this influence extends beyond the private sector.

In the media and in educational institutions the rhetoric surrounding the reasoning to support military families was quickly adopted everywhere. Schools throughout the country started programming dedicated to meeting the needs of military children. Professional bodies like the Association of American Social Workers started competency training courses in military family cultural competency. Viral videos of military family

[36] www.joiningforces.gov. Accessed August 20, 2018.

reunions had an increasing presence on social media. The call to support and strengthen military families was everywhere and it had all started with PSD-9 and the concerted effort that the First Lady Michelle Obama had made to place a spotlight on this issue.

This case shows how supporting military families became a unifying call to action that assembled various sectors of the government to create far-reaching policies that target wellness and resilience. This is an example of how an idea that starts in government travels far and wide. The mobility of this idea and the forms in which it took clearly illustrates how policy operates as an assemblage. In this particular case, the PSD-9 process which involved discussing, grappling with, debating, and reflecting upon the ways in which to best support military families gave new form to a discourse centered around resilience that spanned the private sector, civil society, and government actors. This process reflects the ways in which an assemblage is structured "through critical reflection, debate, and contest" (Collier 2006:400). These observations also build on a literature in anthropology that is concerned with the role documents play in understanding modernity and governmentality (Riles 2006 Hull 2012). Annelise Riles describes documents as "paradigmatic artifacts of modern knowledge practices" that "provide a ready-made ground for experimentation with how to apprehend modernity ethnographically" (2006:2). The documents and diagrams created during the IPC process is rich material to use to better understand the policy formation process.

Conclusion: Policy As Restless Competition

These three case studies show that policy is born of a competitive struggle for recognition. Working at the VA yields personal worth. It is a way of saying to the world

that what you do carries moral weight. This process of marking the self as moral is partly what working at the VA affords. But the conditions that produce this affective stance also have other effects. Using health policy in the pursuit of professional/personal ethical desires makes it difficult to separate what is about oneself from the work at hand. It also generates competition in ways that interfere with collaboration or altogether replace it. The colleagues I had the most difficult time working with shared a common trait – their careers were either ending or they had yet to decide its trajectory. The competition to give can distort by masking self-interest - which allows it to flourish. Advancing a career is a form of self-interest that government is particularly well-suited to afford because of the system of patronage that is at the center of the American democratic political system (Teachout 2014).

In a lecture entitled "Politics as a Vocation", Max Weber explored the ethical consequences of a morally based politics and described a competition to "touch history" (Weber 1917). This chapter outlined three case studies where a similar dynamic was at play in the context of making policy at the VA. This competition meant there were rules about who was allowed to contribute to policy formulation and who was not, even if these rules were mostly implicit. As a newcomer to the organization I had to learn, through trial and error, what these rules were. This learning process entailed understanding where my position, as an employee of the Office of the Secretary, fit in the larger social order of the organization. As I was socialized into where I belonged and where I didn't, there were moments of demarcation that made it uncomfortably clear that my participation was not always welcome.

This was my introduction into agonistic giving, but it was also my introduction into the halls of power and the ways in which power was expressed in the context of the federal government. The marked subject and the unmarked expert is a persistent trope in the academic literature of anthropology (Robbins 2013). But at the VA, it is experts that are marking themselves in the pursuit of recognition and distinction. Distinction is the chance to meaningfully contribute to the policy formation process by maintaining the status quo, as in the first case study, or disrupting it, as in the second and third case studies. Regardless of the outcome, these case studies show how forming health policy is constituted by an assemblage of actors, institutions, and expert knowledge systems that all interact to either bolster or destabilize conventional understanding about veterans' health issues.

CHAPTER 4

THE BLUE BUTTON

How do new ideas get into government? And what happens to them once they do? This chapter attempts to answer these questions by tracing the inception, adoption, and spread of a radical new idea at the VA: the Blue Button. The policies concerning the Blue Button at the VA reveal how policies are instruments through which governments and bureaucracies enact power.

> To adapt a metaphor from Arthur Koestler (1967), policy is the ghost in the machine – the force which breathes life and purpose into the machinery of government and animates the otherwise dead hand of bureaucracy (Shore and Wright 1997: 5).

Policies are the ways in which government manifests its effects. Foucault's work on the "art of government" traces the history of the formation of the state as a new form of political power that changes the relationship between the state and the individual.

> The art of government…is concerned with…how to introduce economy, that is the correct manner of managing individuals, goods and wealth within the family, …how to introduce this meticulous attention of the father towards his family, into the management of the state (Foucault 1978b: 208 quoted in Rabinow1984: 15).

This "art of government" broadened the scope of the political field to include all matters of social life. Foucault's concept of governmentality grows out of these observations and extends his discussions of power by linking the constitution of subjects to the formation of the state. He uses this concept to discuss the ways in which government's widened

scope in modern times has shaped and regulated people's conduct. More specifically, he describes governmentality as "the conduct of conduct":

> …studying the techniques and procedures by which one sets about conducting the conduct of others. That is to say…to pose the question of norms of behavior first of all in terms of power, and of power that one exercises, and to analyze this power as a field of procedures of government (Foucault 2010: loc 448).

This concept links politics to norms. Other scholars have demonstrated that governmentality is best understood as an intellectual apparatus "for rendering reality thinkable in such a way that it is amenable to political programming" (Rose 1996: 42). Miller and Rose build on this further and take Foucault's concept of governmentality and divide it into two distinct aspects: rationalities ("thought") and technologies ("interventions") (2013). Rationalities refer to "styles of thinking, ways of rendering reality thinkable in such a way that it was amenable to calculation and programming" (Miller and Rose 2013: loc 449). Technologies refer to "all those devices, tools, techniques, personnel, materials and apparatuses that enabled authorities to imagine and act upon the conduct of persons individually and collectively, and in locales that were often very distant" (Miller and Rose 2013: loc 448).

Thus the power that stems from the concept of governmentality lies in the ways in which forms of government shape and constrain the actions of subjects and regulate conduct. These effects are more subtle than overt expressions of domination but are more effective because they can easily go unnoticed. Thus the concept of governmentality draws a distinction between the power that is exercised through techniques of self versus through techniques of domination. These ideas take politics beyond the realm of "the

state" and locate the power of policies in their ability to shape individuals. But what about policies that aim to shape structure? What forms of governmentality does dominating domination take? In this chapter I attempt to answer this question by exploring the power of policy at the VA in changing the way governmentality is practiced. More specifically I discuss the Blue Button initiative and the ways in which this innovation, implemented at the VA, escaped control.

The Blue Button

The Blue Button was a technological initiative aimed at giving veterans access to their health records. More specifically, the Blue Button is a web-based personal health record (PHR) that allows users to download their health information as a simple text file or a PDF that can be read, printed or saved on any computer. It is easy to use and enables patients to share their health information with health care providers, and other caregivers.

The Blue Button was the most successful health information technology (HIT) initiative of the Obama administration. As of September 2017, there were 1.8 million unique registered users of the Blue Button within the VA, with over 26 million downloaded files.[37] Currently there are over six million Blue Button users that can be broken down accordingly: one million Veterans, one million Center of Medicare and Medicaid Services (CMS) beneficiaries, one million Department of Defense (DoD) service members, and three million users in the private sector.[38] Part of this initiative's success lies in its widespread adoption in the private sector as well – a rarity for government led innovations. To date, more than 500 payers (insurers), providers, and other health-

[37] Interview with Staff Member #5.
[38] Interview with Staff Member #4

related organizations in the health care industry have taken the "Blue Button Pledge" to "get personal health information out of proprietary silos and into the hands of the consumers and patients who need it".[39]

The success of the Blue Button cannot be separated from the overall concerted focus the Obama administration placed on technology. This focus earned President Obama the title "America's First Tech President".[40] The administration's focus on technology was propelled by an overall desire to make government more transparent and more open. On his first full day of office, President Obama issued his Memorandum on Transparency and Open Government.[41] His goal was to create "an unprecedented level of openness in Government" by bringing a new approach to public administration that emphasized three principles: transparency, public participation, and collaboration.[42] These principles formed the cornerstone of Obama's open government strategy. In a follow-up memorandum, the administration explained the reasoning behind why these principles were good for strengthening the democracy.

> Transparency promotes accountability by providing the public with information about what the Government is doing. Participation allows members of the public to contribute ideas and expertise so that their government can make policies with the benefit of information that is widely dispersed in society. Collaboration improves the effectiveness of Government by encouraging partnerships and cooperation within the

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[39] Accessed October 23, 2017. https://www.healthit.gov/patients-families/pledge-about.

[40] Accessed December 15, 2017. https://www.obama.org/chapter/our-first-tech-president/

[41] Accessed May 17, 2017. https://obamawhitehouse.archives.gov/the-press-office/transparency-and-open-government

[42] Accessed May 17, 2017. https://obamawhitehouse.archives.gov/the-press-office/transparency-and-open-government

> Federal Government, across levels of government, and between the Government and private institutions.[43]

Promoting increased accountability, shared decision-making, and the inclusion of everyday citizens in the work of government all seem like utopian goals. But what do achieving these goals look like in practice?

Drawing on observations from the evolution of the Blue Button program, I argue that the forms of governmentality that attempt to change structure must escape control. To make this argument, I review how and why HIT became the sharp point of the spear for "opening government" at the VA. I pay special attention to the concept of "meaningful use" and the legislation that created it to better understand the impact of the VA's Blue Button on wider changes in the field of HIT and what this instructs about how new ideas spread from government to the private sector. Most importantly, this chapter does not assume that technology will change government. Instead it poses the question: can technology change government? Ultimately, the adoption and spread of the Blue Button reveals many lessons about the practice of governmentality and the limitations of policies that aim to empower people with technology and data.

America's First Tech President

Technology was a big part of how President Obama got to office so it is not surprising that his administration would choose to draw on it as a foundation for policy. President Obama's campaign broke ground on how politicians connect with a digitally savvy electorate which also led him to be dubbed as America's first "social media

[43]Accessed May 17, 2017. https://obamawhitehouse.archives.gov/open/documents/open-government-directive

president" (Freking 2017). In fact, during the Obama administration government literally went social. For the first time ever, the White House joined Facebook, Twitter, Flicker, Vimeo, iTunes and MySpace. The other government agencies, including the VA, followed suit opening social media accounts and building followings that radically changed the way the government engages with citizens. In 2015, President Obama sent his first tweet from @POTUS, an account that currently has 21.3 million followers and is one of the few legacies from Obama that President Trump has embraced.

Obama campaigned on the promise of leveraging technology and innovation to help government better serve the American people and he was quick to take action on this promise. The Memorandum on Transparency and Open government issued on January 21, 2009 instructed the Director of the Office of Management and Budget (OMB) to issue an Open Government Directive. This directive compelled executive departments and government agencies to take concrete, specific actions to implement the principles of transparency, participation, and collaboration that were at the center of the open government initiative. This directive also laid out a guiding framework for how each government agency was to develop their Open Government Plans. Each agency's Open Government Plan was meant to be "the public roadmap" that details how each agency would incorporate the principles of the President's Memorandum on Transparency and Open Government into the core mission objectives of each agency.

For the purposes of this chapter, I will focus on how transparency was operationalized to mean access to data. Under the principle of transparency, the data the Federal Government maintained was considered a "national asset" that should be shared widely and technology was critical in facilitating this access as well as opening "new

forms of communication between a government and the people" (OMB 2009). In order to implement a new era of Open Government, President Obama created new federal positions, the first ever Federal Chief Technology Officer (CTO) and first ever Federal Chief Data Scientist. The Federal Chief Technology Officer, in coordination with the Director of the Office of Management and Budget (OMB) was charged with coordinating the development of an Open Government Directive that laid out how each agency was to implement the principles of Open Government in their work.

More practically this meant each agency would have to develop an Open Government Plan that would implement the principles of transparency, participation, and collaboration. More specifically departments and agencies were asked to take the following steps:

- Publish government information online
- Improve the quality of government information
- Create and institutionalize a culture of open government
- Create an enabling policy framework for open government

The first Federal CTO, Aneesh Chopra, came out of state government and had a technology policy background. His focus on healthcare technology, standards, and open data shaped what Open Government would become. Interestingly, healthcare technology became an important focus for defining Open Government. Chopra's successor, Todd Park, who had a background as a successful serial entrepreneur in the private sector before he became the Department of Health and Human Services first CTO retained the

focus on healthcare technology as a cornerstone of Open Government. Of all spheres of policy, why did healthcare technology become a defining feature of the open government strategy in the Obama administration?

I argue that the answer to this question lies in the definition and primacy given to "high-value information" in the OMB directive on Open Government." According to this guiding document transparency identifying "high-value information" and mobilizing it was imperative. A closer examination of the language in the directive defines the parameters that were given to define "high-value information" and what was to be one with it in the name of operationalizing transparency.

> A strategic action plan for transparency that (1) inventories agency high-value information currently available for download; (2) fosters the public's use of this information to increase public knowledge and promote public scrutiny of agency services; and (3) identifies high value information not yet available and establishes a reasonable timeline for publication online in open formats with specific target dates. High-value information is information that can be used to increase agency accountability and responsiveness; improve public knowledge of the agency and its operations; further the core mission of the agency; create economic opportunity; or respond to need and demand as identified through public consultation (OMB 2009).

These parameters were far and wide and each agency interpreted them to the best of their abilities. In the context of the VA, high-value information became synonymous with personal health care information because of the lifesaving mission that was central to caring for Veterans. In addition, there was a contemporaneous raging debate about "meaningful use" in the field of HIT that would profoundly shape the ways in which the VA operationalized open government.

Meaningful Use

The focus on data that was central to President Obama's Open Government initiative, at its best, was inherently about making government more meaningful to people by making data or "high-value information" available to them. This focus on the "meaningful use" of data in people lives had an important precedent in health care. Before the Patient Protection and Affordable Care Act was passed there was an equally historic piece of legislation passed in 2009 that flew under the radar called the Health Information Technology for Economic and Clinical Health (HITECH). HITECH was passed as part of the $787 billion stimulus package, also referred to as the American Recovery and Reinvestment Act (ARRA) and it encouraged health care providers to show "meaningful use" of a certified electronic health record. HITECH gave the Department of Health and Human Services (HHS) the authority to establish programs to improve patient care by promoting HIT, especially electronic health records (EHRs). Under HITECH, eligible health care professionals and hospitals qualified for Medicare and Medicaid incentive payments totaling $27 billion over 10 years, or as much as $44,000 (through Medicare) and $63, 750 (through Medicaid) per clinician when they adopted certified EHR technology and use it to achieve specified objectives (Blumenthal and Tavenner 2010). The programs that HHS created to implement HITECH became referred to as Meaningful Use.

HITECH was an ambitious effort to compel the health industry to start using HIT across the country. In retrospect, it is hard to fathom the fact that before 2009, life-saving decisions in health care, what may be one of the most information intensive industries, were largely made on paper. A group of scientists went as far as to describe the pre-

HITECH U.S. health care industry as "arguably the world's largest, most inefficient, information enterprise" (Hillestad, Bigelow, Bower, et al. 2005: 1103). Dr. Atul Gawande, the physician/New Yorker columnist described the paucity of data driving health care decisions as an "embarrassment" (Gawande 2009). Gawande goes on to explain:

> At the end of each month, we have county-by-county data on unemployment, and we have prompt and detailed data on the price of goods and commodities; we can use these indicators to guide our economic policies. But try to look up information on your community's medical costs and utilization - or simply try to find out how many people died from heart attacks or pneumonia or surgical complications - and you will discover that the most recent data are at least three years old, if they exist at all, and aren't broken down to a county level that communities can learn from. It's like driving a car with a speedometer that tells you only how fast all cars were driving, on average, three years ago. We have better information about crops and cows that we do about patients. If health-care reform is to succeed, the final legislation must do something about this (2009b).

Though passing health reform proved to be a partisan issue, moving forward with Meaningful Use and HIT was not. Belief in the transformative potential of HIT to achieve health reform dates back to the Bush administration (Brailer 2004). To understand the consensus about HIT's relationship to health reform, I must first define the boundaries of HIT. HIT broadly refers to "an enormously diverse set of technologies for transmitting and managing health information for use by consumers, providers, payers, insurers, and all the other groups with an interest in health and health care" (Blumenthal and Glaser 2007: 2528). There are three specific forms of HIT that are important to define to understand how this technology can improve care: 1) electronic

health record (EHR); 2) personal health record (PHR); and 3) clinical data exchanges. The EHR and PHR are directed to different audiences, physicians and patients respectively. More specifically, the EHR

> …is able to electronically collect and store data about patients, supply that information to providers on request, permit physicians to enter patient care orders on the computer (known as computerized physician-order entry, or CPOE), and provide health professionals with advice for making health care decisions about individual patients (known as decision support) (Blumenthal and Glaser, 2007: 2529).

The EHR is most often used in the clinic or hospital setting with huge implications for changing the way work is organized for providers. In contrast, the PHR is a technology that is designed exclusively for consumers and directly involves them in their own health care process by serving as an interface for engagement. PHRs are a newer form of technology than EHRs and as such are in a newer stage of development in the HIT landscape (Waegemann 2005). The basic definition of a PHR, is: "An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual."[44]

Furthermore, PHRs can be designed in ways that would allow individuals to decide which parts of the information included can be accessed by others, including various medical personnel. Lastly, the clinical data exchanges represent less of a technology than a network of providers and patients that are working in a coordinated

[44] Accessed December 20, 2018. https://www.hitechanswers.net/key-definitions/

fashion to exchange health-related information about consumers regardless of the geographic or institutional setting. The below diagram, Figure 7, illustrates how clinical data exchange operate as currently managed by what are referred to as regional health information organizations (RHIOs). RHIOs are the administrative operating entities that coordinate the exchange of clinical information between PHRs and EHRs across institutions in a geographic region.

RHIOs also provide ongoing governance of the process of data sharing. Data exchange occurs through the information-exchange networks that provide the technical means of exchanging data between the records and databases maintained by clinicians, health care institutions, and individual consumers. A given region, overseen by a given RHIO, may have multiple networks of this kind that communicate with one another. Health care facilities include hospitals, long-term facilities, home health agencies, nursing homes and rehabilitation hospitals.

The VA system is part of several RHIOs throughout the country. These clinical data exchange networks represent an important opportunity to coordinate care for those Veterans that receive dual care, meaning both within the VA system and outside of it. The proportion of Veterans that are classified as dual users varies by geographic region. In the Bronx borough of New York that is home to a VA Medical Center (VAMC) the RHIO administrator cited up to 50% of veterans receive care both within and outside the VA.[45] This makes the work of sharing clinical information across institutional and geographic boundaries incredibly important for coordinating the care of veterans and

[45] Interview with Staff Member #7, July 9, 2016

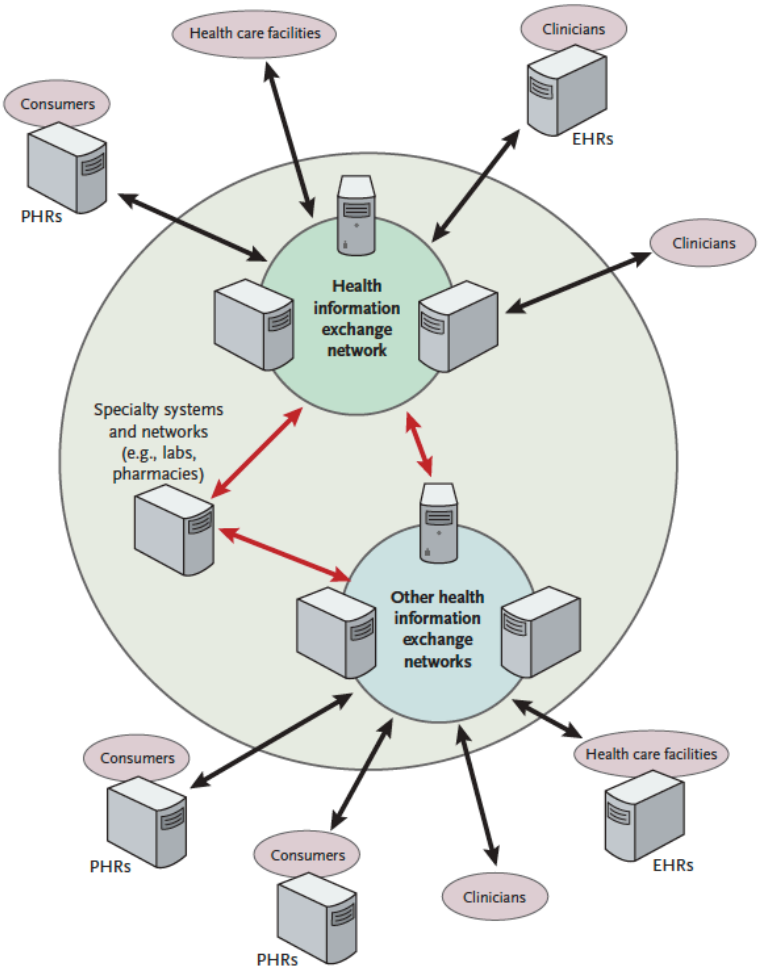

Figure 7, A Regional Health Information Organization (RHIO). Adapted from (Blumenthal and Glaser 2007)

hence improving their population health. Now that the HIT landscape and terminology is clear, how does meaningful use lead to better care?

The Battle for Meaning: debates about Meaningful Use

According to the Meaningful Use legislation:

> The objective of meaningful use is to go beyond the adoption of EHRs by using them in meaningful ways that improve the quality, safety, and efficiency in health care while facilitating engaging patients in their own healthcare. Additional goals include leveraging technology to improve population and public health (American Recovery and Reinvestment Act 2009).

Improving the quality, safety, and efficiency of America's $2 trillion health care industry while engaging patients in their own health care and improving population and public health is a tall order for any piece of a legislation. However, conventional understanding about the ability of Meaningful Use to do this lays in four areas: 1) improving the information that doctors receive through reminders and what is referred to as computerized decision support that enable better and safer clinical decisions; 2) improving the exchange of "interoperable" health information between hospitals and providers that allows the data in a patient's record to be shared back and forth; 3) improving the ability to aggregate and track data about patterns of illness on a population level and the comparative effectiveness of treatments provided (Varley 2011); 4) cost containment of health care expenditures; and 5) increasing consumer access and control over their health information in the hopes that it will increase their engagement in health care decisions. These five areas define the overarching benefits of meaningful use and I will briefly review each.

The first benefit, improving the information that doctors receive through reminders and what is referred to as computerized decision support is about eliminating mistakes and making safer clinical decisions. Medical errors are the third leading cause of death in the United States (Martin and Michael 2016). When doctors enter notes and orders into an electronic system, it immediately eliminates errors that result from inscrutable handwriting and also allows the software to provide a critical function: decision support. In its most basic form, decision support means reminding clinicians to order certain routine tests, like mammograms or colonoscopies, and/or to order treatments like flu shots. It its most advanced forms, decision support can advise adjustments in drug dosing based on changes in the patient's health status or warn about adverse interactions when patients start new treatments that may conflict with medication they are already taking.

The second benefit, better information exchange, is all about having access to a patient's prior health record. When I was admitting patients in a hospital as a medical resident, the care I was able to provide drastically differed between the patients whose past medical records I could access and the patients who I had to admit without access to their records. And this difference was a matter of chance. With each new patient I admitted, I would go down to the medical record room with fingers crossed that there was a paper chart from a prior admission in my hospital that could help me piece together their past. Finding a chart for a patient I was admitting was like striking gold because it insured that me and the team of clinicians caring for the patient had the accurate information they needed to make the best possible treatment decisions instead of basing our decisions on guesses. When patients are admitted into a hospital sick, it is very

difficult to ask them to piece together their entire history – their sick. Interoperable EHRs would eliminate this obstacle to better care.

The third benefit, improving the ability to aggregate and track data about patterns of illness on a population level and the comparative effectiveness of treatments provided, is virtually impossible with paper records. In order to aggregate data and extrapolate findings on a population level, individual health care records need to be entered into electronic systems that can organize and analyze the data. Without EHRs and PHRs, there is no way to capture this information for the purpose of analysis.

The fourth benefit, the potential of HIT to reduce health spending for health care, is a contentious one because the estimates widely vary. But this benefit is largely about the ability of HIT to make care more efficient by eliminating the great deal of waste that contributes to uncontrollable spending. Stripped down to the essentials, this benefit is about avoiding duplicative services and improving providers' productivity (CBO 2008). Part of what makes this benefit contentious is that the U.S. health care industry has long been incentivized to produce duplicative efforts because of what is called the fee-for-service system. Purchasers of health care, meaning insurers and federal entities like Medicare and Medicaid, pay providers for any service they provide, regardless if it was appropriate, duplicative, or an error. This fee-for-service model is widely cited as the main driver of health care costs in the U.S.

The fifth benefit is specific to PHRs and draws on broad conceptions of consumer empowerment in which advocates emphasize the potential for PHRs to increase patient engagement and enhance patient-centered care. There is a democratizing effect that

opening up doctor's notes to patients has for the doctor-patient relationship. The doctor-patient relationship is steeped in an asymmetrical power dynamic that leaves it up to providers to decide what information to give and when. PHRs upend all of this by assuming every piece of medical data can and *should* be shared. Providing patients access to this information allows consumers to participate in their care and allows patients to begin hold providers accountable in ways that were not possible before PHRs. Empowering patients to take control of their health information has been perceived by some providers as taking control away from doctors.

> If I am being honest with you, as a provider, I am not sure it's such a good idea to share everything with patients. Results always have to be interpreted in context and it's my job to do that. Part of my training includes deciphering the information for patients to tell them what they should and should not worry about.[46]

The above staff member, who was also a medical provider, is one of many physicians who have expressed concern about PHRs and the mandate to share information with patients. At the heart of these concerns are issues about who has control. These types of cultural changes underpin the resistance that the adoption of HIT has faced in medical settings.

The HIT czar appointed by President Obama to implement HITECH, Dr. David Blumenthal, was all too aware of the power struggles and described his responsibility of ushering in an era of meaningful use as being less about technology and more about creating a "social transformation" in the health care industry (Varley 2011:1). His successors have similarly stated that changing "the culture surrounding access and

[46] Interview with Staff Member #6, June 6, 2016.

sharing of information" in HIT is critical to promoting its use (Washington et al 2017). In the context of the VA, this was no different. According to one staff member who worked in VHA's IT division and was responsible for leading some of the meaningful use efforts,

> I think these new technologies scare doctors because it makes them feel very exposed. When physicians write their notes, they are used to writing them for other physicians. But if now the patients have access to these same notes, they are going to have think twice about how they write them because they will be judged by a different set of criteria and they are not used to that.[47]

What is this new set of criteria? The VA's CTO at the time, Peter Levin, described part of this new shift as "patient as partner" in health care. "Blue Button technology represents the vanguard of a cultural shift away from the doctor as isolated service provider to patient as partner in the management of their healthcare" (Walker 2011). At the center of this clash of culture between doctors and patients is the thorny issue of who owns the data contained in these electronic records. Another VA staff member who was also a medical provider explains further:

> It's dangerous for people to have access to that information. It needs to be interpreted. It also opens us up to lawsuits. Plus, if we are being honest, I think provider systems worry that if people can walk away with their data then they can walk right into another health care system. As crazy as that sounds, that's the truth.[48]

Prior to HITECH, most hospitals systems had policies that essentially trapped the data in proprietary systems, if they existed, and placed a high burden on sharing this information easily, even with patients. Patients were required to fill out consents and usually wait a significant amount of time before these records could be made available.

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[47] Interview with Staff Member #4, May 3, 2016.

[48] Interview with Staff Member #6, June 6, 2016.

By placing all of these restrictions, providers systems essentially operated as if they owned the data. Hospital systems even had officially policies in place that stated they did own this data. So part of what meaningful use was trying to do was liberate this trapped data by hardwiring a new default in the medical system that acknowledged the fact that patients should own their data. The hope was that by empowering patients to own their health information they would therein use it to improve their outcomes.

But giving unfettered access to patient data was unsettling to many providers. When VA made clinical notes available to patients through the Blue Button "providers complained that they would have to change the way they write their notes."[49] One staff member further explained this point.

> We knew we were going to face resistance to the idea of sharing open notes so we took our show on the road. And what we learned was that it's all about transparency. If the note reflects the encounter patients had then it has therapeutic benefit. And if I feel you wrote something other than you said, then it has the opposite effect. The pitch was that you tell people first and then you do it. I talked a lot about the social life of information. When information created for one purpose is used for another, it can have unintended consequences. So I talked a lot about how to see this as an advantage for providers and the opportunity they now had to write your note in a way that has therapeutic benefit.[50]

Interestingly, changing the behavior of physicians and their practices was at the center of how the VA would implement the adoption of Blue Button. The technology was beginning to force a conversation about a change in the dynamic of the clinical encounter that was laser-focused on transparency.

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[49] Interview with Staff Member #5, June 4, 2016
[50] Interview with Staff Member #5, June 4, 2016

With all of this to gain, why did it take federal legislation to compel the health care industry to widely adopt EHRs? The financial disincentives for doctors to bear the cost of implementing these systems is a widely cited reason for why it required the federal government to intervene in the adoption of HIT. Estimates for an initial investment to implement an EHR system ranged from $40,000 per doctor to $5-10 million per average-sized hospital (Blumenthal 2009). Yet, the cost-savings attributed to the better care these systems would provide was largely to be accrued by the private insurers and purchasers of care, which included the federal government and patients because of the way the U.S. health care industry was organized.

> For example, if a physician with an EHR system decided to order a diagnostic test for a patient, and received an alert that another doctor had already ordered and conducted the test, it saved the time of the patient and the money of the patient's health insurance provider, but it gave no benefit to the physician. In fact, if the diagnostic test was one she would have conducted in her own office, she stood to lose revenue (Varley, 2011: 8).

The inability of providers to capture the financial returns of an investment in HIT is a market failure which makes "no obvious business case for health IT" (Blumenthal 2006: 5) among providers. Even though, as the above vignette illustrates, it is quite clear how implementing HIT systems could lead to potential overall cost-savings in the health care system by eliminating waste that results from duplicate tests and other medical errors. Of note, there is a debate about the magnitude of the cost-savings that HIT systems would yield.

In addition to the financial disincentives, there is a daunting learning curve for physicians that adopt these systems. Migrating from a paper system to a new EHR

involves a great deal of time that physicians have to devote to getting familiar and learning a new way of doing business. According to a Congressional Budget Office report, a great deal of the technology's "value comes when physicians devote considerable time to training, to personalizing the system, and to adapting their work processes to achieve the maximum benefits" (CBO, 2008: 19). In an interview with President Obama's health IT czar David Blumenthal, he described the "psychological transition" that "doctors of a certain age" have to make to adopt these systems as a particularly tough obstacle (Varley 2011:9). A VA staff member had similar comments to share:

> It's hard to change, especially when it means disrupting your life-saving work. Getting an EHR up and running takes time and it usually means things are going to get worse before they get better. What doctor has time for that when they are busy saving lives? Plus, there are older doctors who simply don't like computers and truth be told are a little scared of them. These are the same people that call their kids if they need help with anything electronic. Imagine getting those people to commit to using an EHR. It's a nonstarter. [51]

Another obstacle to the adoption of health IT has been the sub-par technological offerings. Of the over 40 electronic health records available in 2008, many did not meet the minimum requirements in terms of functionalities needed to meet Meaningful Use criteria. Of the EHR solutions that did meet the requirements many physicians complained they were difficult to use and were not designed by physicians for physicians. One of the early lessons from the experiences of health systems that had successfully adopted EHRs, the so called early-adopters, was that a critical key to success was to have physicians driving the process for adoption instead of IT departments (Mason 2010).

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[51] Interview with Staff Member #3, April 23, 2016

Moreover, no system had truly solved what was considered the holy grail of health IT: interoperability.

The ability to share patient data across various hospitals and networks in an easy and secure way defines interoperability. It is likely the largest obstacle in the health IT industry and one that makes investing in EHR solutions particularly tricky. The reasons behind why interoperability has been an elusive goal in HIT is beyond the scope of the study but one notable observation made by President Obama's HIT czar, Dr. David Blumenthal, is that "there are few incentives for software companies to develop software that can communicate easily with competitors" (Blumenthal 2006: 5). A VA staff member shared a similar insight. "If you think about it, there really is no reason for private sector HIT companies to collaborate. That is a part of the interoperability problem."[52] So the risk of making a large investment in a technology that is not going to be inoperable and do what you want it to do was large.

Nonetheless, despite these barriers, by the early 2000s there were a number of early adopters, doctors, hospitals, and health care systems that had begun using HIT systems. Of these early adopters, the Department of Veterans Affairs is credited widely as having the "the largest computer success story" in the U.S. health industry (Himmelstein, Wright, and Woodhandler 2010: 45). The VA embarked on its journey towards Meaningful Use long before HITECH in the late 1990s as part of a major transformation effort that was led by then Undersecretary for Health Ken Kizer. "Between 1995 and 1999, the VA health care system was reengineered, focusing

[52] Interview with Staff Member #4, May 3, 2016

especially on management accountability, care coordination, quality improvement, resource allocation, and information management" (Kizer 2009: 313). A major part of this transformation was the largest ever deployment of an EHR which became known as the Veterans Health Information Systems and Technology Architecture (VistA) (Kolodoner 1997). Between 1999 and 2005, VA health care costs rose at a rate of .3 percent annually, compared to the 4.4 percent annual increase in Medicare spending on health care and the HIT was thought to be an important factor in the reduced health care spending (Varley 2011).

Blue Button

At the VA, giving patients' access to their medical data became a lightning rod issue for Open Government. Blue Button took the idea of ownership and ran with it by becoming the widest implemented PHR in the country.[53] As one staff member explained:

> The medical establishment has tolerated, and in some cases insisted, that patients' data belong to the labs, the pharmacies, the payers, and the clinical care providers. We've spent billions of dollars building IT systems that are digitally isolated and hiding shriveled behind obsolete interpretations of outdated laws to justify a provider- and payer-centric view of the health information access and sharing. As a question of full disclosure I should unequivocally declare that I believe that this is fundamentally ludicrous, it is wrong, and it is lethal. Physicians don't "own" data any more than a bank "owns" depositors money, social networks "own" links and relationships, or a political party "owns" campaign contributions and voting records.[54]

[53] Interview with Staff Member #4, May 3, 2016
[54] Interview with Staff Member #3, April 23, 2016

Those within the VA that supported patient access to data were vociferous and tenacious. The support in the leadership, which came from the top, meant that providing Veterans access to their medical records became one of the flagship open government initiatives at the VA.

VA was setting an important precedent in HIT with the Blue Button that had implications beyond the institution. The reality was, until the Blue Button, very few people, Veterans and non-Veterans alike, could access their medical records. Prior to the development of the Blue Button, the HIT debates were stuck with respect to the proper "standards" that PHRs should assume. Standards "define how information is packaged and communicated from one party to another, setting the language, structure and data types required for seamless integration between" information technology systems (Health Level Seven International 2017). Similar to the longer and more entrenched debates about the standards that EHRs should take, complicated semantic models that had been developed specifically for the retrieval of health information, like HL7, were being considered to handle the clinical information that needed to be imported into PHRs.[55] This complexity came with a price. Emphasizing technology priorities and complicated computer codes meant trading the ease with which "end users", in this case veterans, could navigate the information that the PHR contained.

Blue Button leap frogged the stalemate expert proponents of highly structured data were locked in by replacing the need for minutely structured specifications with a people friendly simple text file – an ASCII file. ASCII stands for American Standard

[55] Accessed August 3, 2012 http://www.hl7.org/implement/standards/index.cfm?ref=nav.

Code for Information Interchange and is comprised of numerical representations of letters and characters in English.[56] Given computers can only understand numbers, ASCII is a set of numbers and characters that allows text-based applications to present content to users. ASCII was developed in the 1960s, when no two computers or hardware manufactures used a common set of characters to translate the alphabet or characters. This led to a Tower of Babble scenario in which there was little interoperability between computers. Even within one manufacturer, there was great variability in the way data was imported. IBM alone used nine different character sets across all its hardware before the advent of ASCII.[57]

Approximately 50 years later, Blue Button reclaimed this old technology as the choice format in a landscape where interoperability of health data standards had paralyzed progress. Blue Button's emphasis on simplicity represents an elegant breakthrough in the HIT world, where computer-based decision support systems tailored to clinical information remain cumbersome and hard to translate. By leapfrogging the obstacles that data standards represented, Blue Button quickly became the nation's PHR. In May of 2012, the Chief Technology Officer of the White House, Todd Park, announced a Blue Button for America initiative that extended the legacy of the Blue Button outside the VA (White House 2012). The aim of the initiative was to scale-up the innovation VA developed and more specifically develop "tools that will help individuals utilize their own health records – current medications and drug allergies, claims and

[56] Accessed August 3, 2012. http://www.asciitable.com..

[57] Accessed August 6, 2012. http://ascii-world.wikidot.com/history.

treatment data, and lab reports – to improve their health and healthcare" (White House 2012). This demonstrates once again how an innovation pioneered in the VA was beginning to change how the country conceives of and responds to health-related challenges.

With each subsequent release of the software supporting Blue Button that the VA issued, the range of clinical information it contained further expanded to include provider-relevant information such as immunizations. With time, the expanded capabilities and functionalities it accumulated meant the impact was ever increasing and the PHR would soon become an EHR. Though the innovation that Blue Button represents is not a panacea for the problems plaguing health care it is a powerful case study of how quickly innovation can be adopted and the role the VA plays as an implementer of policy.

Escaping Control

Blue Button was an idea that no one thought of. The origins of the Blue Button dates back to January 2010. At that time, VA was invited to attend a meeting with federal, private sector, and non-profit HIT thought leaders at the Markle Foundation in New York City as part of the Markle Consumer Engagement Workgroup. The goal of the meeting was to figure out how best to provide consumers with electronic access to data as well as help incentivize market innovators to create HIT solutions using data that would expand the vision of patient engagement in HIT to view consumers as "information participants - not as mere recipients, but as information contributors, knowledge creators, and shared decision makers and care planners" (Markle 2010:11). Prior to this point, a great deal of attention in the HIT community had gone into provider controlled and

directed HIT solutions instead of consumer controlled tools. The conversation about health data was greatly limited to the medical provider community with little thought as to whether or not consumers had access to their health data.

All who attended the Markle meeting, left it with a breakthrough idea named "Blue Button" that would allow consumers to download their health data. The actual technology behind this innovation was relatively simple. The idea was to have a download button, named "Blue Button", that would enable individuals to easily download their electronic health data in a simple reusable file format. To this day, no one who was present at the meeting can pinpoint who came up with name or the idea but everyone who was there takes credit for it.

Members present at the Markle Meeting included representatives from private industry, not-for-profit foundations and the federal government. After the meeting, the federal participants worked at their respective agencies to translate the momentum from the Markle meeting into something that was actionable. The Center for Medicare and Medicaid Services (CMS), the Department of Defense (DoD), and the VA started working together to develop what Blue Button would mean in practice.

From the beginning, Blue Button was a collaborative effort and this spirit of collaboration informed all aspects of its development. Part of what made the collaboration possible across the federal partners was the fact that each partner had a functioning online portals for personal health and claims data that was up and running. This meant they were not starting from scratching in making data available to their

consumers. Instead they would just need to make unifying changes to the format of the data.

The VA proposed the simplest format for the data, namely a text file format. This was the easiest possible format because it meant that no special software would be needed for veterans to translate it. The fundamental simplicity of the format flew in the face of decades of disagreement about interoperable data standards for health information. As one staff member explains,

> I came to the VA and was met with binders of health care format standards. I literally could not believe how many formats had been considered. It was paralyzing to though an action. Who cares if no one can make a decision?[58]

When the VA presented its proposition for the format to other partners everyone did not agree. Some of the most vociferous opposition came from private sector partners who were at the Markle meeting. One company in particularly was advocating for a format that would allow their company to have a monopoly of Blue Button files. A staff member who was intimately involved in managing all aspects of Blue Button development further explains.

> This particular company was advocating for a format that would allow a proprietary system to have a monopoly on Blue Button. They literally wanted their company to be the only one that could handle Blue Button files. And the reality is, that was not an outrageous ask to make of a private sector company in HIT. Unfortunately, making sure health information was locked up in proprietary systems was the way that business as usual has been conducted in HIT. Blue Button had to disrupt all of that. We had to create incentives to collaboration that did not exist in

[58] Interview with Staff Member #3, April 23, 2016

> the private sector. If you think about, there is no reason for private sector companies to collaborate. That was part of the problem.[59]

VA eventually won the argument to keep the structure of Blue Button as simple as possible. But to get to the stage of prototyping the new product they had to make another radical decision, institute a new process for how software would be developed in the organization. How this would be done was under the strict purview of the newly appointed Chief Technology Officer of the VA, Peter Levin.

At the VA, similar to many federal agencies and the private sector, software development is a long, multiyear process that makes it difficult to be innovative or to respond to policy imperatives like Open Government that demand quicker turnaround. Therefore creating a new process for how an idea like the Blue Button could be completed in a matter of months meant re-writing the rules for federal IT development.

This is perhaps where the new class of civil servants that President Obama ushered in, the entrepreneurs-in-residence, as they were called, made their greatest mark. This class of civil servants had the formal title of Chief Technology Officers but their positions had nothing to do with running all the line operations for technology but rather involved setting up new processes that would lay the groundwork for how government did business. These new positions were a clear signal from the Obama administration that government had a great deal to learn from the private sector about harnessing the power of technology and data in new ways that can transform the ways in which government works.

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[59] Interview with Staff Member #4, May 3, 2016

All of the newly appointed CTOs shared an entrepreneurial background from the private sector which they explicitly leveraged in their new civil service positions. Part of the idea was to have the best practices from the private sector inform the ways in which the new CTOs would conduct business in government.

The VA's CTO Peter Levin believed laying down new processes for IT developing in the agency was about cultural change. "This is as much about cultural change and business process change as it is about technology," he said in an interview to *Federal Computer Weekly*, a publication dedicated to providing federal technology executives news and strategic advice. Peter often talked about the cultural change he had to affect at the VA as breaking the cycle of "can't, don't, won't". First on the agenda of changing the culture was changing the ways in which the IT team conducted business.

In order to make Blue Button a reality, Peter started to employ an agile software development model where working software was delivered frequently (weeks versus months) and the product was in a constant, iterative process of development. Delving into the minutia of the growing pains of implementing agile methods in the VA is beyond the scope of the study. But analyzing the person who drove this change is not. The story of the Blue Button cannot be separated from the change agents that were newly hired by the Obama administration to bring the innovation of the private sector into government and in Peter's case, there would be no Blue Button at the VA without him.

The Dream Team

Peter's nickname within the agency was affectionately "Jaws". In a press interview he was asked to explain his nickname and he gave the following answer: "I

clamp on and don't let go. In public service, there's a premium put on being able to stay on message" (Levin in Joch 2010: 29). As a White House Fellow, I shared an office with Peter so I had a front row seat to see Jaws in action.

Once Peter had sunken his teeth into a new idea, he was relentless, especially if it had real value in alleviating the suffering of Veterans. For Peter, providing access to data is more religion than mandate. In a Ted Talk he gave about data he talks about access to data as a "transcendent moral problem". He goes on to explain his reasoning:

> More people die from avoidable medical errors in the United States than from gunshot wounds, breast cancer and vehicular accidents combined. For me this is a transcendent moral problem. And when you start to unpack what the root cause of the problem is you notice that the data is trapped, the data that can save these lives is trapped in sub-terranean strata of paper and obsolete IT systems (Ted Talk 2015).

Peter was a zealot when it came to advocating for access to data and he had the technical chops to match his enthusiasm. He came from a background in academia and the private sector and represented a new cadre of civil servants that were brought in to make innovation in government possible. One staff member described "Peter as the perfect person to drive the back end of the development of Blue Button and Todd [Park] and Anish were great cheerleaders at the front end. It was a trifecta dream team."[60]

But Jaws alone was not enough to liberate data from trapped systems at the VA – he had to find the ideal partners within the government's bureaucracy who would provide a critical pathway for how this data would become available. I interviewed one of these key partners within the VA and she described the success of the Blue accordingly:

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[60] Interview with Staff Member #4, May 3, 2016

> I think of myself as a seed planter because you have a lot of things that can be promising and working for the government you learn to plant seeds because there are many factors that determine the rate at which things happen – including politics. And this was a moment in time where we had a lot of strong leadership at all three agencies [DOD, VA, CMS]. We had a clear, direct benefit for patients. We already had some experience with providing patients with access to their data and they clearly wanted more. And you know I talk about the Blue Button as this simple idea that spawned an era of change.[61]

One of the key decisions that she believes led to Blue Button success was the decision to let go of data standards which is the technical jargon for how the information should be structured and packaged. She explained:

> Early on we wrestled with the idea of trying to implement the current standards even though they were really evolving at that time. We decided to offer the data in a simple text format and then added a PDF option. So that's a good example right…so if people really believed that everything that had to be done had to be compliant to the standards and the standards were not yet ready you could see how you would spend years trying to right-size that. And instead we took a different approach really focused on just getting the data out there.[62]

This was a controversial decision because of concerns about the privacy and security of health information was connected to the standards it should be packaged in. The reality is Transparency comes with risks; especially where private health information is concerned. But these risks can be contained and mitigated. In an interview the VA's CTO summarizes the privacy concerns.

> Are you going to give them the information that they asked for, even if there's a cybersecurity risk, which you can train them to remediate or at least to lessen? Or are you not going to give them the info and tell

[61] Interview with Staff Member #5, June 4, 2016
[62] Interview with Staff Member #5, June 4, 2016

> someone who carried a gun in your name, who shot bullets to defend your liberty, that you are not going to have access to your information because we don't think you're smart enough to keep it private? (Levin in Comentz 2012)

The decision to let go of standards was the beginning of how Blue Button would eventually escape the control that had bogged down prior attempts to give consumers access to their health records.

Impact of Blue Button: Going Mainstream

The former administrator of CMS and a health care delivery pioneer, Dr. Don Berwick, described the success of the Blue Button as: "… an iconic wonderful idea. The Blue Button isn't just valuable, it's magic. It's the open sesame button that will open the door to a whole new level of care" (HHS Health IT Summit 2012). Thought leaders like Berwick were using "Blue Button" to denote not only electronic access by patients to their health data, but also the greater movement toward patient engagement and empowerment that it enables" (Riccardi and Coelius 2013). Berwick's description of the Blue Button as a gateway to better care is also partly about its rapid adoption from government into the private sector which is perhaps its most notable impact. In an interview, the CTO of the VA at the time explained this impact:

> Perhaps the most important thing that has happened-and that we're most excited about - is that the private sector has adopted Blue Button. Everybody can agree that this is government at its best. We didn't spend a lot of money and it didn't need an act of Congress (Levin in Walker 2011).

There were two important milestones that expanded the adoption of the Blue Button to the private sector. The biggest expansion of Blue Button came when the Office of Personnel Management (OPM) requested that all insurance payers for federal employees offer the ability to download personal health information in Blue Button format.[63] OPM is responsible for administering health benefit programs for the civilian sector of the federal government, including all executive agencies, Members of Congress and their staffs, and the federal judiciary. It covers more than 200 separate insurers, which deliver health benefits to more than 8 million employees, retirees, and family members. They officially requested "that Carriers enhance their Health Information Technology (HIT) efforts by adding the ability to download enrollee personal health information, in the Blue Button format(s), from their Personal Health Records (PHR)" (U.S. Office of Personnel Management 2011). The second expansion came in February of 2014 when leading pharmacies in the nation committed to make the information available via Blue Button (Riccardi and Coelius 2013).

Other industries are building on the Blue Button model by replicating the technology to fit consumer needs. In September 2011, former US CTO Aneesh Chopra challenged the energy industry to model a Green Button, off the successful Blue Button, where energy providers would give energy users their consumption data in an easy to read and use format at the click of a button. In January 2012, two major California utilities – Pacific Gas & Electric and San Diego Gas & Electric – announced their implementation of Green Button. Energy customers can manage their consumption via

[63] Accessed June 2, 2012.http://www.opm.gov/new/blue-button-added-to-health-insurance-carriers-for-federal-employees,1744.aspx.

their smart phones using the standard Green Button data format. On January 19, 2012, the Department of Education announced that it would release a MyData button. The MyData button would allow students to download academic data such as transcripts and performance data into a simple, machine-readable file. Organizations like Education Testing Services, Houghton Mifflin Harcourt, and Pearson committed to partnering with the Department of Education are supporting the MyData button as well (White House 2012).

Barriers to Change

In order for an innovation to spread, adoption has to be followed by spread. In the case of the Blue Button, giving veterans access to their data became a part of the My Healthevet (MHV) Personal Health Record Portal. "MHV provides access to VA health care and information 24/7 through web-based tools that empower Veterans to become active partners in their health care. MHV registrants can click a 'Blue Button' on the website to view, print or download their available personal health information and military service information."[64] Blue Button spread throughout the VA because there was an infrastructure in place to support it that was focused on enabling and encourage patient/clinician collaboration. However, outside the VA, adopting the Blue Button encountered some barriers.

At first, it seemed like the innovation of the Blue Button would have no limits. HHS started a Blue Button Connector website to help consumers and patients find their own health information online and to encourage developers to build tools that could use

[64] Accessed September 13, 2016. https://catalog.data.gov/dataset/my-healthevet-mhv

this structured electronic health data.[65] The Blue Button Connector was an attempt to help consumers navigate the fragmented health care industry which scattered health information instead of gathering it. Unlike the VA system, where the health information veterans can be found in one place, the primary challenge to access personal electronic health information lies in finding out where it is.[66] Since most hospital systems have propriety electronic health records that are not interoperable, this health information is usually trapped in small bits in various hospitals. The Blue Button Connector launched in 2014 with the hope of helping find these trapped bits of data. But by May 2017, the website, which was launched by HHS, was being retired. On the homepage of the website there was a notice (see Appendix I) that read: "As of May 2017, information on the Blue Button Connector website will no longer be actively updated".[67] Though no formal reason was given for why the Blue Button Connector website was being retired one VA staff member thought it was related to an overall effort to maintain proprietary systems for electronic health records.

> It's sad really but am not surprised. The DoD awarded a $9 billion-dollar contract to update its EHR and chose a proprietary system. People are making a killing on proprietary systems that are not interoperable. There is no incentive to share when you are making that kind of money.[68]

The contract the staff member is referring to is the competition for the Department of Defense Healthcare Management System Modernization (DHMSM) which was described

[65] https://www.healthit.gov/buzz-blog/consumer/introducing-blue-button-connector/
[66] Interview with Staff Member #4, May 3, 2016
[67] Accessed June 1, 2017. https://www.bluebuttonconector.healthit.gov
[68] Interview with Staff Member #18, January 16, 2017

as "the most lucrative electronic health record contract in history".[69] There was a contentious culture war of sorts that was at the heart of this battle and VA had skin in the game. One of the competing bidders for this contract was a commercial version of the Veterans Health Information Systems and Technology Architecture (VistA), the open source EHR developed and used by the VA.

Open source software refers to computer software whose source code is publicly accessible unlike proprietary or closed systems. The main difference between these systems is that open source software is meant to be shared. VistA code exists in the public domain and is available through the Freedom of Information Act. Several national health systems use VISTA at little cost. Some VA staff members I interviewed felt strongly that EHR modernizations efforts both within the VA and DoD should only be open source. "VISTA was developed by tax payers money. It should be given away. It's also one of the few systems designed by clinicians for the purpose of clinical care. Why go backwards from that."[70] In a survey of over 15,000 physicians conducted in 2016, VISTA topped the list as most preferred EHR.[71] But two years after Cerner won the DHMSM contract, the same company, received another $10 billion dollars to be the sole-source provider for the VA's EHR.[72] VISTA, the same software lauded by physicians as their top choice, was officially dead.

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[69] Accessed November 5, 2018. https://www.healthcareitnews.com/news/how-cerner-won-biggest-ehr-deal-ever-twice
[70] Interview with Staff Member #3, April 23, 2016
[71] Accessed November 6, 2018. http://www.medsphere.com/blog/vista-retains-top-spot-in-most-recent-medscape-ehr-survey
[72] Accessed November 6, 2018. https://fcw.com/articles/2018/05/17/va-10b-cerner-contract.aspx

Similar to the unexplainable retirement of the Blue Button Connector, the decision to choose a proprietary system to be the platform for the "largest electronic health record transformation in the history of American medicine" according to the Ranking Member of the Senate Veterans Affairs committee, Senator John Tester, indicates that the barriers to change in the EHR ecosystem are durable. The structures and incentives to keep systems closed are formidable even in the face of superior technical solutions that physicians not only prefer but cost much less.

Conclusion

This raises the question: how do you measure the success of a new idea in government? One metric the Blue Button case instructs is when it has effectively escaped any level of control and is beyond the reach of technical experts. Another is the impact that Blue Button has had on other industries. Similar to the way in which PTSD among veterans became at Trojan horse for the recognition of trauma in America, Blue Button fundamentally changed the forms in which consumers, providers and the private sector provided access to patient data. It is also another example of how innovations within the VA led to changes in the way the nation responded to challenges in health care delivery beyond the VA. However there were real limits to the spread of the Blue Button that were structural. The proprietary technology that dominates the EHR ecosystem makes it difficult for open source solutions to compete. In an environment where $10 billion contracts are at stake, does a new idea that has the potential to replace the need for proprietary technology have a chance?

CHAPTER 5

VISUAL MEDICINE: MEDIA AS A STRUCTURAL HEALTH INTERVENTION

In the 21st century, the legacy of treating veterans mental health is expanding into new terrain. The VA is employing media and technology in powerful ways that are fundamentally changing the forms of engagement and extending the reach of the organization. In this chapter, the VA's current use of media, social marketing, and technology are examined to explore what this means for veterans and the challenges of representation that the institution faces in the public sphere.

The VA's use of media leverages the power media has to construct and reflect reality. Media is a battleground for the politics of representation because it is a powerful vehicle to naturalize representations about identity. Media mediates experience and contributes to the way we see ourselves. Media circulates and transmits ideas about how one should inhabit the world and becomes embedded in the social words of those who receive it. That is why an important theme in the anthropology of media literature is the ways in which communities draw on media to craft identity and produce new individual and collective identities (Abu-Lughod 2005; Spitulnik 1997; Schiller 2011). An important construct for all of these works is Habermas's "public sphere" (1974). Habermas explains this concept in the following passage:

> By "the public sphere" we mean first of all a realm of our social life in which something approaching public opinion can be formed. Access guaranteed to all citizens. A portion of the public sphere comes into being in every conversation in which private individuals assemble to form a public body (Habermas 1974: 49).

The public sphere is the site in which hegemonic and counter-hegemonic narratives about identity are constructed. In this chapter, I discuss the digital public sphere the VA has created in the form of the Make the Connection (MTC) campaign and the ways the institution is using this digital public sphere to address the cultural barriers to seeking mental health care veterans face. At the center of this effort is the VA's work in changing the cultural representation of who constitutes the category of "warrior". This example offers insight into what it means to use media and technology to craft counter-hegemonic narratives about veterans that "write against" hegemonic cultural constructions about warriors and the so-called "warrior myth" (Ivie and Giner 2016).

More specifically, this chapter explores the MTC campaign which was rolled out by the Department of Veterans Affairs (VA) in 2011 to encourage veterans to seek care for their mental health issues and to learn from other veterans how to live well. The campaign uses web-based videos of veterans' stories, print ads, and social media to connect veterans and their families with the experiences of other veterans and ultimately to connect them with the information and resources they need to work through mental health conditions and a variety of common life experiences. The anchor of the campaign is a website that features over 400 autobiographical veterans' stories that have accessed treatment and are in various stages of recovery. Drawing on this campaign, I explore how the VA is constructing a new cultural representation of what it means to be a warrior and how this form of cultural action is being used to heal veterans and in the process help the institution gain a foothold on re-presenting itself.

The assumption underlying this campaign is that stories can do things through their persuasive power that information delivered otherwise cannot. This raises the relationship between stories and action, and in particular the nature of this relationship within healing. Medical anthropologists have described healing encounters as "dramatic episodes" where patients and healers play out their respective roles (Laderman and Rosenman 1996 :1). Other medical anthropologists have written about the co-construction of therapeutic dramas, "healing dramas" that structure experience (Mattingly 1998). Mattingly argues that seeds of narrative are already in the experience of healing. Mattingly's work explores the role that narrative plays in structuring the interaction of occupational therapists and their patients and makes an argument for how the healers needed to "emplot" their patients' actions into stories in order to reach the desired outcome and render themselves effective.[73] Thus a narrative structure is part and parcel of the actions that heal. Similar to Mattingly's narrative structure of a therapeutic experience that leaves patients transformed, the VA is using narrative to generate a therapeutic experience for veterans that facilitates recovery (1998). By "recovery" I mean its clinical sense, which has been defined as a:

> …deeply personal, unique process of changing one's attitudes, values, feelings goals, skills, and/or roles. It's a way of living a satisfying, hopeful, and contributing life even within the limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony 2000:159).

[73] Coined by the philosopher Paul Ricoeur, "emplotment" refers to a causal continuity that structures a narrative in the same way as the plot of a story.

The VA's use of these stories to help veterans begin their journey towards recovery is about making and remaking identity. This work places the observation that "personal narrative simultaneously is born out of experience and gives shape to experience" (Ochs and Capps1996: 20) to therapeutic use.

I argue the VA is employing a similar use of narrative to structure experience that builds on Mattingly's work. However there is an important point of departure which is that the institution positions veterans as both healers and patients. And in the latter case, what is interesting is that the audience is the yet unseen patients that have not entered into care. This difference means that veterans are the ones that are co-constructing healing with other veterans while the VA simply provides the interpretive frames that weaves these therapeutic dramas together and in so doing gives it a new structural form that collapses the voice of the VA with the voice of the veteran. Anthropologists have written that stories, also referred to as narratives in the literature, "incorporate three different perspectives: the characters, the audience, and the narrator" (Mattingly 1998:37). In the case of the MTC campaign the use of narratives blurs the boundaries between these perspectives in ways that build and reflect the concept of "mediascapes" (Appadurai 2003).

Appadurai's concept of "mediascapes" (2003) is useful to understand the VA's use of media as a therapeutic intervention that is blurring the boundaries between state and private interests. In particular, this use sheds light on the problematics of the "many complicated inflections" that blur the boundaries between the state and civil society and widens its purview into modern life (Appadurai 2003: 43). In Appadurai's formulation,

> …mediascapes, whether produced by private or state interests, tend to be image-centered, narrative-based accounts of strips of reality, and what they offer to those who experience and transform them is a series of elements…out of which scripts can be formed of imagined lives, their own as well as those of others living in other places (Appadurai 2003: 43).

The VA is using veterans' video-based stories to create a mediascape that can serve as a reservoir for the community of veterans in the public sphere who have not accessed VA services to re- imagine themselves and in so doing access care. Using veterans' stories to help veterans heal from mental health issues involves using the currency of stories to help them re-imagine themselves. This use is a practical expression of the observation that "narrative and self are inseparable" (Ochs and Capps 1996:20). The interconnectedness between narrative and selfhood parallels the inextricably intertwined themes of selfhood and morality or said alternatively "selfhood and the good" (Taylor, 1989:3).

Within the medical/psychological anthropology literature on mental health the moral dimensions of selfhood are deeply related to mental health problems. Arthur Kleinman has shown that being recognized as "moral" or "good" is important for mental health and healing (1999a, 1999b). In fact, moral agency, defined as "one's capacity to act autonomously, to be self-determining, to make a life plan that reflects one's values, interests, and hope for a future" (Blacksher 2002: 460), has been identified in this literature as a key driver of the mental health recovery process (Myers 2015). In the mediascape that MTC has created, listening to other veterans' stories is a building block for creating social ties to the VA as well as reconnecting to themselves. The MTC campaign with its website, Facebook community, and YouTube channel, constitutes a

mediascape where counter-hegemonic constructions of warriors can circulate and gain traction. This use of media to shape identity by the VA grounds theoretical concerns about media as a social practice in altogether new ways.

Using stories to re-imagine selfhood in ways that help veterans get a better grip on reality is not new. "Life stories express our sense of self: who we are and how we got that way. They are also one very important means by which we communicate this sense of self and negotiate it with others" (Linde 1993: 3). However, the VA's use of life stories has created a new structural form for healing that re-imagines the meaning of the public sphere. The digital database of veterans' video stories that can be seen in people' homes is creating virtual community where the currency of exchange is stories and social ties are being created through the exchange of these stories online. The media world that the MTC has constructed is an alternative public sphere where the currency of exchange, stories, are being gifted in similar ways that reflect the spirit of the hau in Mauss's gift exchange. In response to the stories that are presented on the MTC website, Facebook page, and YouTube channel, other veterans in the digital public sphere share their own thoughts and personal stories similar to Maussan gift exchange. In Mauss's classic work, gift exchange created cohesion in a social group by keeping the gift in motion (1925). This movement is characterized by three actions: to give, to receive and to reciprocate. Similarly, the MTC uses stories as currency that can be given, received, and reciprocated as a gift. The entire point of the campaign is to gift stories that can heal and continue to keep these stories in motion. In the examples of the stories that I discuss in this chapter, veterans talk about sharing their stories as an obligation that must be reciprocated similar to the ways in which Mauss describe the obligations "to reciprocate the present that has

been received" in gift exchange (1925: X). These stories are changing the cultural representation of who warriors are in ways that are inherently political because they call into question the actual human cost of war. These stories also offer new meaning to the "imagined state," one that places returning veterans at the center (Gupta 1995).

Veterans' suffering and failed responses to veterans' suffering is a rich source for media coverage that has a strong influence on the ways in which the VA is perceived. But the VA as seen through the "imagined state" the MTC campaign constructs is altogether different. Taken as a whole, the 400 veterans stories that comprise MTC is a powerful collective cultural product that is attempting "the recovery of non-hegemonic voices" and in so doing re-presenting the state (Scott 1990:19). However, this cultural product also raises an important question: what does it mean for the state to construct narratives about warriors that may not serve its interests? The answer lies in the way that the VA is using media as a structural health intervention which I discuss in the conclusion to this chapter.

Media and myth-making: constructing the warrior archetype

The hegemonizing uses of media by the military to recruit soldiers and manufacture public support for war has a long legacy that involves Hollywood and the advertising industry. I discuss both below and the role that each played in creating representations of who warriors were and how this would eventually influence the VA's efforts to respond to mental health problems. The paradigmatic example of the state producing and deploying media to serve its interest is in military recruitment efforts. For example, the advertising campaign "Be All You Can Be" which was the Army's recruitment slogan for over twenty years was ranked eighteen in a list of top one hundred

campaigns of the 20th century by *Advertising Age*, the principal trade publication of the advertising industry (Ad Age1999). The history leading to this campaign, which is chronicled in Beth Bailey's *American Army* (2009), coincided with a massive increase in the army's marketing budget and a change in the institution's approach to recruitment.

In the wake of Vietnam, public sentiment about the army was at an all-time low, and youth culture at the time was markedly anti-authority. Against this backdrop, the army had to try something new. As Bailey comments:

> The army, relying on market logic in its attempt to create and maintain a volunteer force, defined the market as a site of consumer desire, a sphere in which the emotional weight of individuals' hopes and dreams and fears was more powerful than that of rational decisions based on practical information (2009: 76).

The new slogan "Be All You Can Be" rebranded the army as an institution where everyday people could reinvent themselves. This campaign enumerated the many benefits of enlisting, money for college in particular, and made them concrete. Following this reasoning, joining the army became a path to college. Bailey argues that "Be All You Can Be" helped "shift understandings about the meaning of military service from obligation to opportunity" (2009: 197). Below I will discuss a few of the early commercials that appeared on television as part of the Be All You Can Be campaign and common themes across them. These examples are meant to be illustrative rather than representative of how media was used to shape public perceptions about who a warrior was and what serving in the military meant, both of which informed veterans' attitudes and practices long after they left the military.

One of the earliest TV commercials[74] that was a part of the Be All You Can Be campaign starts out with a picture of a high school graduating class with voiceover that declares: "Right now, the one thing you want most is an opportunity". Then the image changes to scenes of young army recruit's trains and intercuts between scenes from civilian life where the same recruits are learning in class or making their families proud. The intercutting between military life and civilian life makes the case for how serving in the military prepares you for civilian life. As this intercutting is playing the music jingle begins: "Be all that you can be. Keep on reaching, keeping on growing. Be, all that you can be. Cause we need you. In the Army." This commercial was explicitly targeting recent high school graduates and framing the army as an opportunity to secure their future. The images used portray the army as a place recent high school graduates could go to grow and learn in ways that would make themselves and their families proud.

A 1984 commercial[75] starts out with soldiers in a helicopter preparing to parachute in to the unknown. The jingle begins: "You are reaching deep inside of you. For things you never known." Then the soldiers parachute down and along with them a hefty army vehicle is parachuted down as well. The jingle continues: "It's been tough going. But you haven't done it alone." The soldiers land in a field along with their vehicle and they run and release the tank from its parachute and get inside as the voiceover begins: "We do more before 9 AM then most people do all day." Then they drive off to their destination as the jingle comes in: "Be all that you can be". Next the soldiers have arrived and are stopping for a break to drink water and relax. One of the soldiers greets

[74] https://www.youtube.com/watch?v=qpmgPuidFb4
[75] https://www.youtube.com/watch?v=ms9pxvEblLs

his superior: "Hey First Sargent. Good Morning." The jingle continues over the group bonding and taking a break: "find your future in the Army".

So much is packed into this 30-minute spot. It begins with the dramatics of soldiers parachuting out of helicopters alongside their vehicle which communicates a heroic larger than life aspect to the work that may appeal to anyone who wants to be a hero. Next, we see and hear that all this action and drama is achieved as part of a team that collectively achieves more in the early hours of the morning than anyone can do alone in a full day's work. Who wouldn't want to be part of a team like that? But the clincher is the three words that come at the end: "find your future". In these three words the jingle encapsulates an achievement that arguably most young people desire. These three words are part of how recruitment efforts transformed the meaning of military service from an obligation to an "opportunity".

In another commercial, a father calls to his son. His mother and sister are in the background listening in. The father asks: "Can I tap your computer expertise son?" Next, we see the son, who is dressed in his uniform and is in the office say: "So you finally gave in". Then it cuts back to the father who continues, "For starters how does the disk fit in the disk drive?" The voice of the narrator comes back in with: "The army can train you to program, operate, or fix computers." Then we cut back to the father asking another question: "What does the printer interface do?". The son answers: "It lets the computer talk to the printer." At that point the father tells the mother, "They talk to each other". The mother responds with "What do they say?" The son continues, "Then there's a telephone modem hookup". The narrator comes back in and says, "And the computer training you get is yours forever." The commercial cuts back to the father as he hands the phone to his

wife and he sits in front of the computer. The jingle begins: "Be all that you can be." The mother grabs the phone and says "looks like you're not going to be the only computer expert around here" as the daughter and father look on excitedly. The commercial cuts back to the son smiling on the phone as he listens to his mom and the jingle ends with: "Get an edge on life. In the Army."

There are so many themes that get communicated in this spot ad. First, the soldier is in an office setting surrounded by computers and technology which is a stark contrast from the prior commercial that depicted soldiers jumping out of helicopters. This distinction communicates a range of possibilities for what service can look like that appeals to prospective recruits who are more interested in technology than the heroics of parachuting. In addition to appealing to a different sensibility, the soldier in this advertisement is positioned as a resource for his family to call upon in terms of knowledge as well as time. The soldier is the person of the future who is comfortable with the technological advancements and has the ability to translate that future world to his family who is still operating in the past. This trope of helping your parents along is also a cultural trope that resonates to a wider audience of young adults who may be familiar with how often their parents need help with new things. Lastly, the closing line that includes "get an edge on life" is a clever play on words that builds on the theme of military service as opportunity, as affording a competitive edge on life.

A 1985 commercial[76] begins with high school students and graduates sitting in an Army recruitment office in their civilian clothes talking about the various fields they are

[76] https://www.youtube.com/watch?v=5qOjkDEHiog

interested in entering. The first prospective recruit asks: "Do you have anything in aviation?" Then the voiceover begins: "The army's most technical training." Then a young woman sits down and asks: "Are there any openings in communications?" We then see a computer screen with technical codes appearing on the screen as we hear the voiceover complete the thought that technical training "… is also the most popular training." Next, we see a young African-American man sit down and say: "I really like computers." Then the voiceover comes back: "So it really pays to have a reservation". At first when I heard this line, I wasn't sure what the narrator meant - until the end of the commercial when it becomes clear they are targeting recruits who are still in high school. Next, we see another prospective recruit talk about his interest in electronics. The narrator continues from the line about having a reservation to: "If you qualify, you can get a guaranteed reservation for the training you want up to twelve months in advance even if you are still in high school". Then we get a close-up shot of the computer screen that shows the recruiting officer booking a reservation for training and the jingle comes in: "Be all that you can be". Next, the army recruiting office turns to the high school student and says: "We'll see you after graduation" and jingle continues "find your future in the army" as the high school student is shaking hands with the recruiting officer and the commercial ends.

The overarching theme across these commercials is the common desire for success. These ads make the army synonymous with achieving success in both military and civilian life. The successful warrior who performs well on the battlefield will perform well in his/her civilian life. The slogans “Find Your Future” and “Get an Edge on Life” both position the army as a pathway to success and characterize warriors as successful.

These ads also reflect the opportunity that military service provides for life after the army and positions the army as a social good for all (Bailey 2009). Though the army had its share of problems as an institution, by the 1990s it was also a site of equal opportunity and inclusion because “the army offered more opportunity to racial minorities and to women than almost any segment of civilian society” (Bailey 2009: 219).

The cultural representation of what the army was and who warriors were change with time. In 2001, "Be All You Can Be" was replaced by a new advertising campaign - "Army of One" that was short-lived due to criticisms about its focus on the individual rather than the team. In 2006, "Army of One" was replaced by "Army Strong". "In an army of social good, a movement had begun to reinvigorate the army's warrior culture and the army's warrior image" (Bailey 2009:225). Strength as the hallmark of a warrior gained renewed focus. So much of the world had changed when this new advertising campaign was introduced. The global war on terror had begun and the Iraq and Afghanistan wars were raging. The U.S. Soldier was depicted in these campaigns as a warrior that was invincible in war. This campaign dovetailed a major transformation in the army led by then General Eric Shinseki, the future Secretary of the VA. This transformation was about creating the army of the future, which was labeled the Objective Force, and defined as being "fully networked, rapidly deployable…with the lethality and survivability of current forces, but with reduced logistic footprint and improved sustainability" (AUSA 2002). Accompanying this transformation was a change in the Soldier's Creed - an oath all soldiers take.

The new creed replaced "I am a member of the United States Army" with "I am a Warrior and member of a team," and centered on a four-line statement of the "warrior ethos":

> I will always place the mission first.
>
> I will never accept defeat.
>
> I will never quit.
>
> I will never leave a fallen comrade (Bailey 2009:249).

The "Army Strong" campaign ads incorporated the lines from the warrior ethos into their advertising efforts and constructed an archetype of the strong warrior that never accepted defeat. These ads were broadcast over TV, print, and radio and painted a picture of the soldier that was infallible and invincible. These depictions of strength reflected the transformed objective force which was comprised of soldiers that had no limits. This archetype of the strong warrior was not necessarily new. The archetype of the invincible soldier had long existed before "Army Strong," but the ad campaign gave it new form and wider circulation with an unprecedented number of advertising dollars behind it.[77]

The myth of the warrior has been studied extensively by scholars who are veterans themselves (Lifton 1973; Egendorf 1986; Grossman 1995). As Lifton notes:

> The warrior has always laid claim on our emotions. He has been celebrated by virtually all known cultures for his individual courage, and for the

[77] With the roll out of the "Be All You Can Be" campaign, the advertising budget of the army grew by 600 percent (Bailey 2009). This has only since grown. The Army currently has the biggest ad contract in the federal government, spending more than $200 million annually on marketing efforts (Ad Age http://adage.com/article/news/army-rolls-strong-campaign/112420/).

> collective glory he makes possible. The quest for such glory is, in turn, part of man's general struggle, in the face of inevitable biological death, for a sense of immortality (1973: 25).

The theme of glory is central to the representations of soldiers that the military has long constructed for purposes of recruitment. This theme underpins a cultural value placed on the honor and distinction that accompanies being a warrior. This identity is something to be proud of because it represents an achievement - according to the myth. It is also a symbol of strength.

The military has a history of protecting the strong warrior archetype that includes suppressing representations of warriors that reflect otherwise. The most extreme example of this repression took place in 1945. After Pearl Harbor, many Hollywood studio executives, directors, and actors enlisted or received commissions in the armed forces. Among the most notable recruits was the film director John Huston. During WWII, he directed three documentary films while enlisted as part of the Signal Corps Army Pictorial Service. He was initially approached by the War Department to essentially create propaganda that would generate public support. But his discerning eye and ethnographic-film like methods had the opposite effect. The truth that his films reflected were more than the military had bargained for. This was particularly the case with his film *Let There Be Light* (1946).

The War Department initially approached Huston to make *Let There Be Light* to educate the American public about the psychological consequences of war and more specifically make the point that veterans who had undergone psychological treatment were in fact employable. Huston shot the documentary over the course of three months at Mason General Hospital in Long Island, NY. He followed a group of veterans from their

arrival through their treatment and right up until their discharge. His preference for unscripted documentary gives the film an ethnographic quality with long unobstructed takes that capture the reality of post-traumatic stress disorder, long before PTSD was named. What he captures on film is powerful. In his own words:

> …there were people who couldn't walk who had to be carried in and who were not paralyzed for any functional reason… who had hysterics and men who couldn't talk and men who couldn't remember… amnesia, aphasia, stammerers and men with terrible, violent ticks and so on (Huston in Lowe 2012).

When *Let There Be Light* screened at the Pentagon it faced unprecedented resistance from the army for the ways in which it portrayed the American soldier as being vulnerable. It was quickly met with swift resistance and the army suppressed it from being released. When the Museum of Modern Art attempted to screen the film in June 1946, two military policemen showed up and confiscated the print (Vogel 2012). The military suppressed the film for nearly thirty-five years. The official reason given by the army was that that it violated the privacy of its participants. But this claim was unfounded given the fact that soldiers in the film had signed releases. Huston soon found out, however, that the consent forms had all "mysteriously disappeared" (Lowe 2012). In his autobiography, Huston goes on to explain his understanding of why the Army suppressed it:

> I think it boils down to the fact that they wanted to maintain the 'warrior' myth, which said that our Americans went to war and came back all the stronger for the experience, standing tall and proud for having served their country well. Only a few weaklings fell by the wayside. Everyone was a hero and had medals and ribbons to prove it. They might die, or they might be wounded, but their spirit remained unbroken (Huston in Lowe 2012).

Huston did not set out to make a film with counter-hegemonic representations of soldiers. In capturing the truth about what war does to the psyche, and bearing witness as closely and unobtrusively as he did, he wielded the double-edged sword of media power. His efforts show that media is not only a tool that reflects power relations, it can help resist them by creating alternative imaginaries that produce new forms of identity that are resistant to state power. Huston showed the vulnerability of soldiers that challenged the propaganda the military espoused and the cultural constructions of the strong warrior.

The cultural construction of the strong warrior archetype that the military has actively shaped over the years has served the state by populating the public sphere with representations that align with its propaganda. When warriors are strong and invincible, there are less questions about the cost of war. But the truth is war breaks people. The former Secretary of the VA, Max Cleland, a veteran himself, sums up this observation:

> War can take it all out of you. I don't care how prepared you are, I don't care which war you find yourself in. War can take it all out of you. It can take away everything that you thought you knew about coping with this life. I know that. It can take away your life we know that. But if you survive war, it can also take away your will to live and I know that too (Cleland 2010).

In recent years, the rising rate of suicide in the military has made it painfully clear that the propaganda of the invincible warrior, with no limits, is a lie. And though the dominant representations that circulated in the public sphere had served the state's interest in the past, times were changing and there was no longer a single story the state could tell about who warriors were in the face of the crisis in representation the VA was facing.

Unpacking the "single story" about the VA

In a famous TED talk titled "The Danger of a Single Story," that has close to 15 million views, the feminist Nigerian writer Chimamda Adichie discusses the politics of representation as it relates to popular coverage about Africa in the West. She famously declares that the "single story" about Africa's pain and woes creates a stereotype that dominates representation at the expense of all the other stories that should be told about Africa. She goes on to succinctly explain the problematic nature of stereotypical representations: "The single story creates stereotypes and the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story."[78] Building on her observation, I would like to explore the single story about the VA that exists in the public sphere.

This story about the VA was perhaps best captured in the Academy Award-winning film by Oliver Stone, *Born on the Fourth of July,* which starred Tom Cruise and was based on the true story of the Vietnam Veteran turned anti-war activist Ron Kovic. In the film, the VA is depicted as an indifferent bureaucratic institution where Veterans go to die. In 1972, Kovic famously interrupted Richard Nixon's GOP presidential nomination acceptance speech and said: "I'm a Vietnam Veteran. I gave America my all, and the leaders of this government threw me and others away to rot in their VA hospitals" (Kovic in Pearson, 2014).

Countless press articles about the VA over the years have only solidified this perception. In 1970, *Life Magazine* ran a cover story titled "Our Forgotten Wounded"

[78]https://www.ted.com/talks/chimamanda_adichie_the_danger_of_a_single_story?language=en

which included damning photos of neglected veterans in the VA accompanied with a harsh critique that called it a "medical slum" (Child 1970). The photos (insert photos) include pictures of rats in traps and overflowing trash cans next to paralyzed veterans who have no choice but to live among the filth. The veterans own words in the article are even more damning than the photos:

> Nobody should have to live in these conditions….We're all hooked up to bring bags, and without enough attendants to empty them, they spill over the floor. It smells and cakes something awful. The aides don't commit themselves wholeheartedly, but with what they earn a year why should they? I've laid in bed on one side from 6 am to 4 pm, without getting moved or washed. When and if you do get a shower, you come back and you're put into bed on the same sweaty sheets you started with. It's like you've been put in jail, or you've been punished for something (Dumpert in Child, 1970:28).

These depictions reflected the shortcomings of the VA post-Vietnam when it struggled to meet the demands of returning Veterans from Vietnam in a context of underfunding. Throughout the institution's history, post-war periods have always been difficult because of an influx of new veterans into its system of care on top of the demand that caring for aging veterans from prior era costs the system. But the chronic underfunding of the institution by Congress is never part of the story that gets told about the VA in newspapers, magazine articles, and television. Instead, the media tends to focus on stories of bad actors and possible corruption because these stories are simpler to understand and also politically beneficial (Moore in Burns 2017). They are beneficial to liberals who want to make the argument that social services are underfunded, and they are beneficial to conservatives who want to make a cause for big government failing. Between these two opposing viewpoints, the latter dominates coverage about the VA.

I was well aware of the negative coverage of the VA in the media, as well as the history of scandals that had cast a long shadow on the institution, when I started working there. But what I quickly learned in my time there as an employee, and then subsequently in my fieldwork and interviews, was that there was another side to the VA that had nothing to do with failures and scandals. This other side was replete with technical experts that had so many initials at the end of their names that it was hard to decipher, along with lifelong career civil servants who were all there to do one thing – to try to do right by veterans.

The chasm between the representation of the VA in the public's eye and the everyday work I was a part of for one year, and then observed for two more, was striking. It was almost like there were two different institutions operating in plain sight. I did not understand how the public perception of the VA could exist alongside the VA that I was intimately witnessing from the inside. Then the scandal of 2014 hit, and these two institutions collided right as I was studying both.

I discussed the specifics of the waiting time scandal and the circumstances under which Secretary Shinseki was forced to resign in Chapter 2. Here I focus on the representation of the scandal in the media. The headline on CNN read "307,000 veterans may have died awaiting Veterans Affairs health care, report says". That report was the VA Office of the Inspector General's (VAOIG) report released on September 2, 2015. But in the actual report, it very clearly states that "due to data limitations, we could not determine specifically how many pending records represent veterans who applied for health care benefits" (VAOIG 2015). Without knowing how many of the 307,000 veterans applied for health care benefits it is not possible to determine how many of them

could have potentially died. Nonetheless, the headlines lead the public into believing otherwise.

"CBS This Morning" reported that criminal charges were possible and that 57,000 veterans had been waiting more than three months to see a doctor. On "CBS This Morning", Wyatt Andrews reported that the effort to conceal the wait times was motivated by bonuses on the line. CNN reported that 40 veterans died while waiting for care at the Carl T. Hayden VAMC. The IG reviewed this claim as well and found that at least 17 of these veterans did not die due to wait times (Alderman and Reed, 2014). Defense One, the sister site to The National Journal ran a headline that compared the scandal to Benghazi: "VA Scandal Could Be Worse for Democrats Than Benghazi".

None of the coverage points to the understaffing of primary care doctors that was the main driver for the scandal or the imposition of a 14-day wait time that was not properly resourced. In other words, the structural determinants of the health care system that contributed to the outcome were not even mentioned. The underreporting of the funding issues is particularly problematic because in February of 2014, Senator Bernie Sanders, who was Chairman of the Senate Committee on Veterans Affairs, asked for $24 billion appropriation to cover the costs of healthcare at VA and was denied by Senate Republicans. But after the wait scandal broke, Congress ended up giving the VA $16 billion presumably to help fix the problem. Why didn't this make headlines too?

In the context of coverage about the VA, reporters have referred to this skewed coverage as "scandal journalism":

> But falling victim to shallow, speculative coverage that haplessly fuels a partisan witch-hunt isn't the answer. For, when mainstream news coverage routinely mischaracterizes the extent of misconduct or failure while ignoring the actual conditions that make misconduct and failure more likely, it becomes derelict in its duty to the public. This is the trap of "scandal journalism"—being obsessed with the theatrics leads to overlooking the facts. It's all distraction and no solution. All of us, especially our veterans, deserve better (Alterman and Richardson 2014).

But what is it that scandal journalism is distracting us from? Recent reporting sheds light on this question and the single story about the VA. In a lengthy *Washington Monthly* article, Alicia Mundy reports the Koch brothers and their affiliates are behind the way the VA was represented in reporting about the scandal, as well as why the coverage reached a feverish pitch. The nonprofit Concerned Veterans for America (CVA), backed by the Koch brothers, has been engaged in behind the scenes trench warfare working with corporate medical interests and key republicans to exaggerate scandals at the VA "as part of a larger campaign to delegitimize publicly provided health care" (Mundy 2016). In a transcript of a closed-door meeting of GOP donors that the then Executive Director of CVA, Hegseth attended with Charles Koch, Hegseth reveals the central role CVA played in "promoting the VA scandal and subsequent legislation, but also about its broader plans to undo worker protections and, ultimately, gut Big Government and unions" (Mundy 2016). An excerpt from the transcript is below:

> Concerned Veterans for America is an organization this network literally created to empower veterans and military families to fight for the freedom and prosperity here at home that we fought for in uniform on the battlefield. . . . Now, unless you've been living under a rock for the last couple of months, you know about the crisis at the Department of Veterans Affairs. What you probably don't know is the central role that Concerned Veterans for America played in exposing and driving this crisis from the very beginning.

After years of effort behind the scenes privately and publicly, the scandal eventually made national headlines when initially in Phoenix it was exposed that veterans were waiting on secret lists that were meant to hide the real wait times veterans had at VA facilities of months and months and months. Veterans literally dying while waiting on secret lists that benefited only bureaucrats.

In driving [inaudible] and monitoring this crisis, we utilized the competitive advantage that only this network provides: the long-term vision to invest and the resources to back it up. We focused relentlessly on both exposing the failures of VA bureaucracy and improving the lives of veterans, meeting our people where they're at.

The Concerned Veterans for America issue campaign pushing for systemic reform of VA bureaucracy is of critical importance, we think, for three key reasons. First, it is going—it has produced and will produce more market-based public policy victories that will improve the lives of veterans and their families; second, it provides the perfect opportunity to educate the American people about the failures of big government; and three, to position us for the long term as a trusted, effective, and credible grassroots organization we can build upon. . . .

Two pieces of groundbreaking VA reform legislation passed the House of Representatives with an overwhelming majority. . . . And Nancy Pelosi and the majority of collectivists voted for them. They didn't like the bills, but they had to vote for the bills because they were outnumbered by a new, nimble, and principled movement of veterans. . . .

Ten days ago, the Senate struck a historic deal, a deal that Concerned Veterans for America was central to in every aspect, literally ensuring that the language stay focused on real market-based reform, and we pushed the ball across the finish line. . . . This bill would empower the secretary to actually fire a manager for cause . . . [and veterans] will literally get a card and the ability to visit a private doctor if they need.

The latter reform, which seems like a no-brainer to everyone in this audience, is a huge development, rocking the core of big-government status quo in Washington. The option for veterans to choose private care upends how the VA has fundamentally done business for the last seventy years, attacking the very heart of the failed top-down, government-run, single-payer health care system that's failed veterans.

> Throughout this effort, Concerned Veterans for America, along with our network partners, have intentionally broadened the debate to include big-government dysfunction generally, further fortifying a new skepticism that AFP [Americans for Prosperity, the Koch-funded political advocacy organization] and others have brought to what government-run health care does (Mundy 2016).

This transcript reveals that the representations circulating in the media are part of a larger cultural struggle for the soul of VA health care. The legislation that Hegseth is referring to is the 2014 Veterans Choice Act which allocated $10 billion for veterans to use vouchers to purchase care in the private sector and which many see as the first step towards privatizing the VA. The removal of the Secretary of the VA, Dr. David Shulkin, who staunchly opposed privatizing the VA, by President Donald Trump in March, 2018, seems to be the second step.

Without going into too much detail, there are several problems with the proposition to privatize the VA. First and foremost, the VA has evolved as a very specialized system of care that caters to the needs of wounded Veterans and represents a model of care that would be nearly impossible to replicate in the private sector (Shulkin 2017). Secondly, the standard of care in the VA is better than the private sector and multiple studies have proven this (Shulkin 2016). Thirdly, privatized care would be completely unmanaged, and uncoordinated. This means it will be impossible to track and measure outcomes. I will discuss this legislation further in the next chapter, but for my purposes here, it is interesting to note CVA's tactics and methods focused on the cultural practice of representation. This use of representation by a nonprofit in civil society that is working with GOP leaders to get an agenda through Congress is an expression of Gramsci's "war of position" whereby political struggle is constituted by "a politics of

partial connections and alliances" (Geertz 1997:10). Politics becomes disguised and enters the cultural terrain in a war of position.

How did the VA make a case for itself in this new terrain? By taking control of its representation in new ways that constitute the Make the Connection (MTC) campaign. This campaign is a powerful antidote to the misrepresentations about the VA's failures that have long defined its single story in the public sphere.

The Birth of Make The Connection

The Make the Connection (MTC) campaign was a response to the dire unmet mental health needs of Veterans. Although there have been conflicting reports about the precise rates, there is a general consensus that the rate of suicide among veterans is higher than in the general population (Blow et al. 2012). One study reported that the suicide risk among Veterans was 66% higher than the risk observed in the general population (McCarthy et al. 2009), while another study has shown that veterans are twice as likely to die from suicide compared to the general population (Kaplan et. al 2007). The statistic that is given in most news reports is 22 veterans die every day from suicide (VA 2012). Though there are many determinants that contribute to increased suicide rates among Veterans the most important are undiagnosed, and therefore untreated mental health disorders. The key barriers that prevent veterans from receiving needed mental health care from the VA include: mental health related stigma, lack of understanding and awareness about mental disorders and mental health care services, and poor perceptions about the VA. Targeting these barriers became a priority at the VA.

During my time at the VA, it was also very apparent that the news coverage about mental health issues among Veterans was starting to frustrate staff working there. Many felt that the press stories and popular coverage was sensationalizing the issue and casting veterans in a negative light. In a VA blog titled, "The 'Dangerous' Veteran: An Inaccurate Media Narrative Takes Hold", the VA went on record about the misrepresentation of PTSD and argued that portraying all Veterans as "dangerous" and "ticking time bombs" was unjust. They further argued that this misrepresentation was irresponsible and more importantly had unforeseen negative consequences that could deter Veterans from disclosing their experiences of service and/or deter college admissions offices and future employers from welcoming veterans into their environments. These sentiments also came out in the interviews with staff:

> The added exposure on mental health issues comes with a cost. I think it is really irresponsible to consequently frame these issues in the extreme. Clearly Veterans have many strengths that make the ideal employment candidates. But that gets lost in the messaging.[79]

Was there any truth to the statement that the added exposure on mental health came with the cost? While I was at the VA I started to pay closer attention to the stories about veterans' mental health issues in the public space. The first story I saw was a Dr. Phil special on PTSD among returning veterans. The show included veterans with different members of their family sharing the difficulties about the illness. The stories ranged from vets who were struggling with addiction because of untreated PTSD to a wife whose husband had set her on fire. Dr. Phil talked to both the vets and their family

[79] Staff member interview #11, August 10, 2016

members and asked them questions about their life stories and what they were doing to cope. At the end of the show, Dr. Phil offered his guests treatment, which I appreciated. He reviewed the steps that they would need to take to heal and ended the show with some promotion about books that discussed how to heal from PTSD. Overall, it was a balanced coverage of the issue. But not all of the coverage the issue was getting was fair.

There was an HBO feature documentary film about the issue of PTSD called *Wartorn* that generated a great deal of press and made huge impressions at the VA. The film traced the history of PTSD as told through veterans' stories dating back to the Civil War. The film begins with old footage from an U.S. Army film titled "Psychiatric Procedure in the Combat Area" (1944) in which soldiers returning from WWII describe horrors of war and the difficult feelings they experienced because of it. From there a narrator reads old letters from a union soldier fighting in the civil war that describes symptoms of PTSD. The film goes through several stories of soldiers throughout different eras to paint a sweeping history of PTSD. In the film General Odierno, Commander of U.S. Forces in Iraq, speaks with candor about the problem of PTSD and suicides. "Our training, from the first time you come into the army or the marine corps or anywhere else, it's about becoming mentally and physically tough. So it becomes difficult for some of these individuals to admit they have problems" (Odierno in Burns 2012). He goes on to explain that estimates of PTSD in the military are as high as 30% and that no one is immune to it. The filmmakers had given free copies to the VA so the film was circulating widely among VA staff. The staff had mixed reviews about the film. One staff member told me she found it "unethical" and "crazy that they put all that stuff

in there but don't mention one word about treatment." Her annoyance stemmed from the fact that the most important, and potentially life-saving information, was left out.

It was a fair point. In talking with her, I realized the Dr. Phil segment I saw may have actually been the exception when it comes to talk about treatment. The fact that PTSD could be cured was not something you heard that often in news stories about this issue. In truth, I didn't even know there was an effective cure until I started working at the VA. Dr. Sonja Batten, the former Deputy Chief Consultant for Specialty Mental Health at the VA, shared some insights about the selective portrayal of PTSD in the media:

> The truth is, PTSD doesn't have to and shouldn't impede success in everyday life for veterans. Years of research have demonstrated again and again that most people recover naturally after experiencing potentially traumatic events, and we have effective treatments for those who develop more significant problems with PTSD. I think what gets lost in these stories are the amazing strengths that our nation's veterans have…We have made progress in the fight against PTSD stigma…veterans are now more likely to recognize if something is wrong and come forward so that they can move on with their lives (Hoit 2012).

So if there are effective treatments for PTSD, whose responsibility is it to communicate about that?

The VA answered that question with the creation of a public awareness campaign called Make the Connection. The Make the Connection (MTC) campaign was rolled out by the Department of Veterans Affairs (VA) in 2011 to encourage veterans to seek care for their mental health issues and to learn from other veterans how to live well. In the VA's press release introducing the campaign it describes the goal of the campaign as being "to help [veterans] confront the challenges of transitioning from service, face

health issues, or navigate the complexities of daily life as a civilian." The anchor of the campaign is a website that features:

> …numerous veterans who have shared their experiences, challenges, and triumphs. It offers a place where veterans and their families can view the candid, personal testimonials of other veterans who have dealt with and are working through a variety of common life experiences, day-to-day symptoms, and mental health conditions. The Web site also connects veterans and their family members with services and resources that may help them live more fulfilling lives.[80]

Exploring the ways in which this campaign uses visual media in service of the VA's broader mandate for outreach reveals what this new form of outreach offers as a critical intervention for improving the population health of veterans as well as what it offers for re-presenting the VA. The heart of the website is the archive of veterans' stories which has been organized into categories that can be searched according to the experiences listed in Appendix A. These experiences are grouped into three main categories: 1) life events that vary from death of family and friends to retirement and ageing, 2) signs and symptoms of mental health issues such loss of interest or alcohol/drug problems; and 3) conditions that include formal diagnoses such as PTSD and depression as well as substance abuse.

Categorizing the digital archive of stories according to these groupings organizes the information into building blocks for making connections that tie veterans to each other and to the VA. In addition to being able to search the stories by these categories and

[80]Accessed November 3, 2018. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2207

experiences, it is also possible to search the stories by demographic variables, such as gender, service branch (army, navy, etc.), era of service (Vietnam War, Desert Era, etc), combat experience, and whether you are a family/friend. This archive of stories is also connected to a MTC Facebook page and a MTC YouTube channel where the content is cross-posted and Veterans can engage with it by leaving comments and questions that VA staff can respond to. When the VA rolled the campaign out, the associated Facebook page was the fastest growing Facebook page in the military/government sector.[81] The MTC Facebook page currently is an online community of 3,022,433 people that are connected and engaging with the content that gets posted all the time.[82] The VA also monitors this page and tries to respond to the thousands of comments that get posted there as a way of doing outreach.

Using stories to educate is not new but the form this particular use has taken is. The fact that these stories are searchable by shared experience and various attributes connected to an online home that connects a website to a Facebook page means the VA has hardwired peer support in the digital space. The innovation in form lies in the way the campaign creates an opportunity for Veterans to learn from other Veterans based on shared experiences in the privacy of their own home.

The target of this new form for peer support is equally interesting. In a VA blog about the MTC campaign, a senior leader of the mental health team asserts that these stories "are helping to change the way our culture thinks about mental health." In order to better understand why this leader has positioned culture as the target of these campaigns I

[81] Interview Staff Member #11, August 10, 2016

[82] Accessed March 3, 2018.

will explore the first advertisements and stories that were rolled out with the campaign. The fact that these were the *first* ads and stories that introduced the campaign to the public matters because it was these first stories that defined the parameters for what MTC was to become.

Bryan's story: "There was a time when there was just no laughing"

The first print ad (see Figure 8) features a veteran named Bryan. It ran in the magazine *Car and Driver* and targeted male veterans of the Iraq and Afghanistan wars. In the ad we see a young male marine named with the quote: "There's a whole community of Veterans out there who just want to help." Under Bryan's name are dates of when he served and in what service. Bryan's image is the largest one in the ad and sits in the foreground. But in the background there are a variety of other images that include letters to his family, pictures of his friends and girlfriend, as well as smaller images in the banner towards the bottom of the ad where he is dressed in his combat fatigues on a landing strip. Under the images there is a summary of Bryan's story that presents the frame that the VA would like this story to be interpreted:

> Bryan served his country and wants other Veterans to hear his story. Coming home wasn't easy - from difficulty sleeping and arguing with his wife to feeling on edge all the time and being anxious when driving. He overcame these challenges by finding resources and reaching out for support. He made the connection. You can, too.

This is the moral of the story that VA would like for the audience of veterans or family/friends of veterans who sees this ad to take away. This interpretive frame is where VA's voice as narrator of the overarching campaign comes in. Though these are all first-

Car&Driver • OEF/OIF/OND Males • Bryan

Figure 8, Make The Connection Print Ad, Bryan

person stories, with veterans narrating their own lives, there is a collapsing of perspectives/voice when the frames for each of these ads are presented. In first person stories, the narrator and character are one in the same. But the summarizing frames that accompany all of the ads in the campaign, whether it is the summary in the print ads or the language that accompany the social media postings on YouTube and Facebook, which I review below, position the VA as a second narrator. This position of VA as narrator has an authority which draws it strength from the interpretive ability to present the lesson of the story. I play close attention to these frames in the ads and social media postings to better understand how VA is using them.

Underneath the frame presented in Bryan's ad is the web address for the MTC campaign and a QR code. The web address and accompanying QR code is at the bottom of every ad that will be discussed. When you scan the QR code on a mobile phone it takes you to a video of Brian's story on the MTC website. The title of Bryan's video is "There was a time when there was just no laughing" and it's five and a half minutes long and features himself, his wife Rebecca, his mother Myra, and his brother Eric, who was also a veteran. In the video, Brian describes his military service and his life afterwards. The narrative is clearly structured as having three acts, like a film. The first act is about who Bryan was before he went to war, the second act is about what happened to him in war, and the third act is about how he recovered from PTSD. This narrative structure sets up the problem the video focuses on which is the transformation of who Bryan was before the military, a "happy kid," and who he became after, someone who had lost the ability to feel and laugh.

Bryan served three tours in Iraq and was a marine from 2003-2008. He talks about wanting to be in the military since he was a kid and more specifically “since the first episode of GI Joe” he saw, he “wanted to do that.” Next, Bryan talks about life in the military and he recounts his traumatic encounter with a bomb. He was hit three times by four bombs during his second deployment. He explains how he had to numb himself in order to survive in that environment and that he didn’t realize “how messed up” he was until he returned to the U.S. Upon his return he describes having “pretty horrible nightmares”, a lack of focus, flashbacks, anger, and a general apathy for life. Bryan explains how he “couldn't feel any excitement about life. Nothing….I stopped talking to my friends. I isolated myself. I would just stay in a room all day and just drink and drink and drink and drink. I didn't know why." Next his wife talks about the effect this had on their relationship and how he began to shut her out. The symptoms that Bryan described are all classic expressions for PTSD. At this point, the narrative takes a turn. With no segue, Bryan reveals a realization: "I knew I had PTSD but I didn’t know I’d be scared to drive on a simple American road.”

After this revelation the video moves into its third act, help-seeking and recovery. The third act begins with Bryan explaining how military training, and what it teaches you, makes it difficult to confront PTSD:

> As military people you find it very difficult to admit your own weaknesses because that's also against…completely contrary to the military philosophy. So when you have PTSD or you have anything like that or any sort of emotional stress you just suck it up.

Next, Bryan's wife and his brother Eric talk about how the they encouraged Bryan to seek help. Then Bryan's mother Myra shares her observations about Bryan: "There is a sadness there, there is something that was lost but what I have is a hope that somehow it will get better." Next Bryan talks about visiting psychologists at the VA and receiving therapy. He advises veterans to surround themselves with good people that want to see you do better and "to take advantage of programs at the VA. Or the nonprofit organizations that are there to help veterans out". He goes on to re-define courage by placing it in the context of seeking care. He states: "It takes a lot of courage to go against that military training that you have to admit that there's something that's broken inside you. You need to fix it. That's the very first step." Bryan closes the video by encourage other veterans to go to the VA where they will find "a whole community of veterans that just want to help you out". After Brian finishes this last thought a closing title card with the VA's logo in the top corner and the name of the campaign, Make the Connection, appears with the website address.

Bryan's story was posted to the MTC YouTube channel on Oct 19, 2011 with the following frame:

> From a self-described 'happy kid' to a determined Marine - Bryan returned home thinking he'd forever lost the ability to feel. Hear him tell how he overcame IEDs, post-traumatic stress, and the unique challenges of a long-distance romance. Bryan got his life on a better track with help from the VA.

This frame clearly shows a structure that VA has constructed for presenting Bryan's story with a beginning, middle, and end to the story. This structure is VA's attempt to emplot Bryan's actions and in so doing present a meaningful whole (Macintyre 1985; Mattingly

1998). "Plot is that structuring device which gives poetic narrative its capacity to deal in universals by placing actions within a coherent whole with a beginning, middle, and end" (Mattingly 1998: 28). VA's post about Bryan's story to the MTC campaign has a similar emploting structure. The structuring role the VA plays by providing these interpretive frames positions VA as a translator of veterans' experiences as well as positions the institutions as being comprised of, in Bryan's words, "a whole community of veterans that just want to help you out". Bryan's story has been viewed on YouTube over 1.4 million times and has been shared 1,266 times on Facebook and garnered more than 6,600 "likes". This means that 1,266 people and everybody in their network have been exposed to Bryan's story and 1,266 people found his narrative important enough to share in their network.[83]

Bryan's narrative had many notable aspects to it but the most relevant for understanding why this new form of outreach represents a cultural innovation, and by that, I mean it is targeting changing culture, as the VA press release described earlier, lies in what he said about military training as being part of what makes it difficult for veterans to admit they have a problem. Soldiers are socialized to "suck it up", not let it out. When he states that: "It takes a lot of courage to go against that military training that you have to admit that there's something that's broken inside you", he is reframing the default position of sucking it up as a weakness. In other words, it takes courage to let it out. This is the beginning of a new warrior archetype these stories are constructing that can be viewed as counter-hegemonic. Bryan's story is also notable for being a good example of how one veterans' story of PTSD actually involves a whole family. One of the striking

[83] Accessed March 13, 2018.

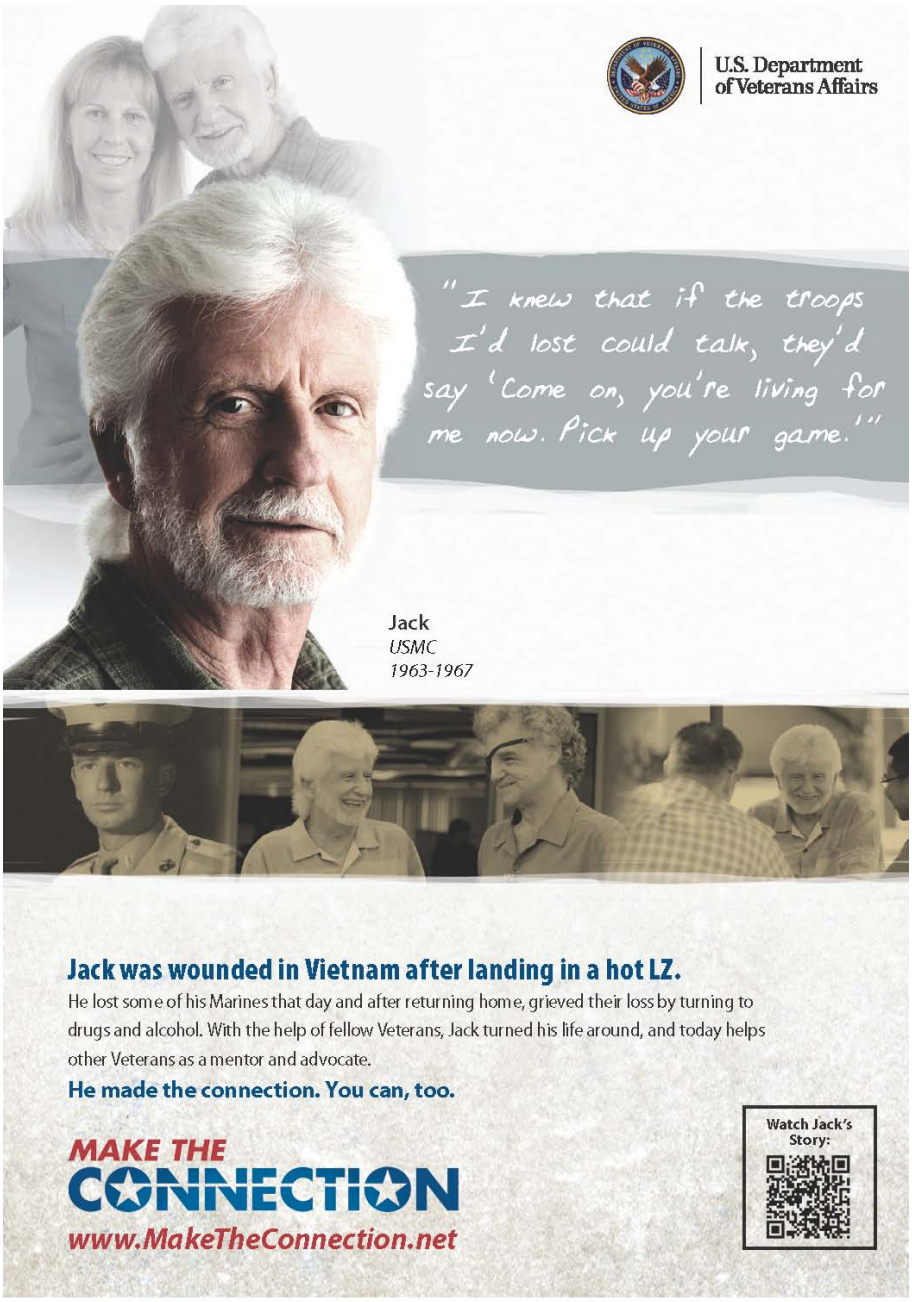
aspects of the construction of this story is Rebecca's narrative. She represents the majority of Americans who know nothing about PTSD and as viewers listen to her story they go along that journey from knowing nothing to actually seeking caregiver support. Whether it's Bryan's story or Rebecca's, part of what both stories do is take viewers on a journey from not seeking care to accessing treatment. This is exactly the behavior and journey that the VA wants modeled/replicated in the general public.

Jack's Story

The second ad features a veteran named Jack (Figure 9), who served in the marines from 1963-1967, and ran in the *AARP Magazine* targeting an older demographic of Vietnam veterans. In the ad, next to Jack's face is the quote: "I knew that if the troops I'd lost could talk, they'd say 'come on, you're living for me now. Pick up your game.' " In the background, towards the top of the ad, there is an image of Jack embracing his wife. Then below the quote and photograph, there is a banner of smaller pictures that show Jack as a young marine and Jack laughing with other veterans. Below the banner of smaller images towards the bottom of the ad there is a summary of Jack's story that serves as the frame:

> Jack was wounded in Vietnam after landing in a hot LZ.[84] He lost some of his Marines that day and after returning home, grieved their loss by turning to drugs and alcohol. With the help of fellow Veterans, Jack turned his life around, and today helps other Veterans as a mentor and advocate. He made the connection. You can, too.

[84] LZ is an abbreviation for the "landing zone" for an aircraft.



Field & Stream • Vietnam • Jack

Figure 9, Make The Connection Print Ad, Jack

Once again, the frame presents a structure that has a beginning, middle and end. Underneath this summary is the Make the Connection logo and the QR code which is connected to Jack's video story on the main website.

The title of Jack's video is “We Are All In This Together” and is a seven-minute video that introduces Jack and the work he does as a VA peer educator. Similar to the prior video there is a three-act structure where the first act introduces Jack, the second act is about his experiences in Vietnam, and the third act is about what motivates him to do his outreach work. The video begins with him walking into a naval hospital in San Diego, referred to as "Balboa", where he works with younger veterans whom he refers to as "kids". He expresses how much he "loves them” and describes them as "the real deal." Next Jack's wife, Barbara, talks about how great it is for the younger veterans to interact with Jack because they feel comfortable with him and because he is such a giving person. Next, we see Jack sharing his story with his “kids” at the VA. He describes the sense of disorientation he felt upon returning from war and how he had "freeze-dried” his emotions.

The second act begins with Jack holding up a picture of himself as a young marine as he recounts getting shot in Vietnam and the eventual addiction to drugs and alcohol that led him to end up in a psychiatric hospital. He then shares the same realization that was on the print ad: "Somehow inside, I realized that the kids that I'd lost overseas were as old as they were going to get. And if they could talk to me they would say, hey, come on, you're living for me now." Next his wife talks about memories of how withdrawn he had been and not understanding what it was at the time. Then Jack talks about his treatment and starting group therapy at the VA in 1979 and how it saved his life.

In his words, "I got into that room, and I was able to exhale". Next, we see Jack run into and embrace an old friend who had also served with him in Vietnam and was also in his 1979 group therapy cohort. As he recounts his friend's story Jack gets emotional because his friend was severely wounded in the war and Jack got overwhelmed expressing the gratitude he felt that his friend made it out alive. The spirit of comradery that they share in this scene is quite moving. Next, Jack talks about the monthly psychiatric care he received from the VA. Then we see him talking to a group of veterans: "I don't think you can deal with the war when you're drinking. And I don't think you can stop drinking until you deal with the war." Next, we hear from a young veteran that was part of the group who was praising Jack for all the help he was providing them. This younger Veteran described Jack as a “Dad” who was “always there to listen, always there to help, always there to guide, because he's been through so much more than we could ever go through. And he was willing to prevent you from going through from the lessons that he's learned." Jack builds on this thought by sharing his own motivation for doing this work as being a missing piece of his own recovery process. He explains that in his case: “there weren't a lot of older guys telling us that it was going to be okay. From the Korea or World War II, we kind of had to figure that out on our own. But once we figured it out, we said, hey we gotta pass the torch to them."

Next, one of the hospital administrators echoes the importance of vet-to-vet support and Jack’s wife Barbara, talks about her own work with the wives of veterans and testifying to them that a successful relationship is possible on the other side of all the challenges that combat stress brings with it. Jack then closes the video with advice for other veterans and a plug for the VA: "Do not isolate and pull yourself away from

existence. That's not a path to health. And the VA is crucial, crucial to the recovery of these guys. It's a safety net. Find the place where you're supposed to be in this mosaic of overall help. Serve again. Don't give up."

Jack's story on YouTube has been viewed 548,935 times.[85] Jack's story was posted on Facebook May 20, 2013 and shared 400 times and liked over 5,400 times. It was posted again on May 30, 2016 and shared 2,909 times and liked over 41,000 times. The increased number in the second posting are presumably attributable to the rapid growth of the MTC Facebook group which means a much larger number of people saw the second posting. Jack's story is about love and empathy. He loves the younger veterans he works with and they feel it. But Jack's love for them was also about a connection to those he had lost on the battlefield. The motivation that he had to live his best life because those who passed could not is a theme that gets expressed in other videos that are a part of this campaign. His practice of serving these younger veterans was also an act of remembrance for those he lost. Jack's conviction to "pass the torch" also conveys the role that empathy plays in this campaign. Veterans have the capacity to heal each other because they have been in each other's shoes. By the end of the video, it's hard not to love Jack. So when he incorporates the VA in his story and declares the crucial role the institution plays as a first step in the recovery process, the VA becomes a part of his story, and by extension part of a story about veterans helping other veterans. It is in this weaving of personal narrative with institutional identity that the VA is beginning to re-present itself.

[85] Accessed April 10, 2018

Nicole's story

The next ad features an African American woman veteran named Nicole (Figure 10), ran in *Cosmopolitan* magazine, and targeted women who had served in the Iraq and Afghanistan wars. Nicole served in the US army from 1990-1993, and the US Air Force Reserve from 1996-present. The quote in the ad reads: "I didn't realize at the time the impact on my children". Underneath her image is a banner of smaller images that show air force planes and service members holding a flag. The summary of Nicole's story beneath the banner frames the ad accordingly.

> Nicole served in the Army and the Air Force Reserve and coming home from deployment wasn't easy. As a medic treating Service members injured by IEDs, she turned off her emotions and became detached. Returning home, Nicole struggled to fit back in with her family. Learn how she tackled these challenges and got help from VA. She made the connection. You can, too.

Nicole's story was titled "VA doctors understood the stress my family faced" and was posted to the MTC YouTube channel on Oct. 19, 2011. The framing description that accompanied her video was:

> While overseas, Nicole did her job and focused on surviving. Back home, her children were affected by the stresses of having two military parents. When she returned, Nicole came face-to-face with her family's challenges and had to deal with her own issues, too. Learn how Nicole found support and resources for herself and ways to help her family thrive.

Nicole's story begins with her explaining that she met her husband in the training for active deployment and that they were a dual military family. Nicole goes on to explain

Cosmopolitan • OEF/OIF/OND Females • Nicole

Figure 10, Make The Connection Print Ad, Nicole

the stress that a dual military family faces because of the fact that someone is always in harm's way, which she describes as stressful to cope with regardless of age. While her and her husband were both deployed to Bosnia, her mother, who was living in California, had to move in with them in Texas, to take care of their children. While deployed in Bosnia, she describes an incident where her young lieutenant was blown up by a landmine and she had to patch him back together. This incident was a turning point. She explains: "From that moment on, I became a little detached, which, of course I brought back into my family too. As a medic, to me, my survival was just to become detached and just be there, and just not think." She goes on to explain disbelief regarding things she witnessed. She then describes the impact her absence had on her kids and the worry it created. She described how "withdrawn" her daughter became and how her son "acted out". She describes all the memories she missed with her kids and the anguish of leaving a baby who did not recognize her upon her return.

In the third act of the video, Nicole talks about her own issues manifesting in the form of obsessive-compulsive disorder (OCD). She describes being very demanding on those who loved her which created an "intimidating household" where no one could ever do anything right. With medication, it became easier for her to see that she was the problem. She talks about her experiences accessing care and the "love" she has for the Texas VA system. She explains: "I've had nothing but like, a love and a personal connection with the people who are treating. They really go out of their way. I mean the phone calls, the letters - everything." Nicole's closing thoughts are about isolation and the team work it takes to get better: "No one can do this alone. We went where we went as a

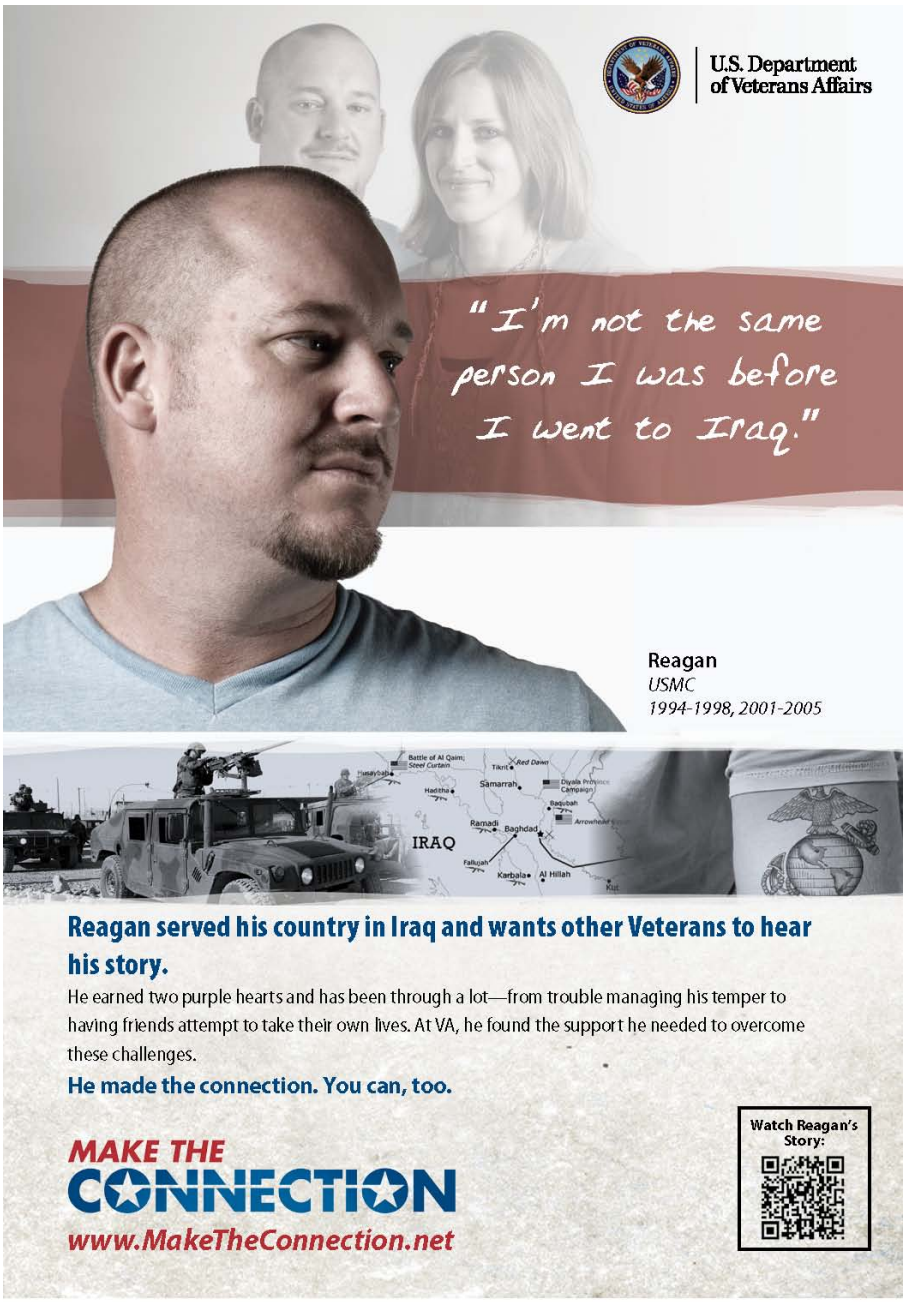
team, as a platoon, as a squad, and we did it together. So, the only way to overcome what we did together is to continue to work together to do that."

The VA features prominently in Nicole's story. She uses the word "love" to characterize the institution and the title of her story emphasizes that the VA understood her needs and was willing to listen. Both aspects paint a picture of the VA that is strikingly different from the single story discussed in the prior section. Of note, Nicole was also the only non-combat veteran in the first ads that were rolled out. This detail teaches that even if you did not participate in combat yourself, bearing witness to the horrors of wars is enough to leave you transformed. An excerpt from her story was posted August 17, 2017 on the Facebook page and was shared 4,306 times and received over 54,000 likes.

Reagan's story

The next ad (Figure 11) is about a marine named Reagan. The quote in the main part of the ad states: "I'm not the same person I was before I went to Iraq". This is a common refrain that is heard from veterans who have returned from war and are feeling unspoken trauma. In the lower banner there are smaller images that consists of a battle map of Iraq, Reagan's tattoo which is the emblem for the marine corps, and a soldier on his battle vehicle pointing a gun. The summary of Reagan's story below the images describes how the VA framed his story:

> Reagan served his country in Iraq and wants other Veterans to hear his story. He earned two purple hearts and has been through a lot - from trouble managing his temper to having friends attempt to take their own lives. At VA, he found the support he needs to overcome these challenges. He made the connection. You can, too.



Popular Science • OEF/OIF/OND Males • Reagan

Figure 11, Make The Connection Print Ad, Reagan

This ad was placed in the magazine *Maxim*, a mainstream men's magazine "with content that promises to seduce, entertain and continuously surprise readers". This ad targeted young, post 9/11, veterans. The QR code on the ad links back to a story about Reagan's life on the MTC website which is also posted on the YouTube channel.

Reagan's video is titled "I'm not the same person as I was before Iraq" and is four and a half minutes long. Regan's video was posted to YouTube on Oct. 19, 2011 with the following frame:

> Reagan came back from deployment but found that life wasn't the same because he wasn't the same. He felt on edge all the time and had trouble controlling his temper. Finally, a fellow Veteran set him on the right path and he got help from VA.

This frame presents a chronological structure to Reagan's story that can serve as a blueprint for how any veteran with PTSD can access care. Regan came home, he had symptoms, he was in denial about these symptoms, but eventually he sought care thanks to another veteran who reached out. Reagan's narrative begins with him discussing how "he hit the ground running" by starting a job on his third day back. He talks about how he worked seven days a week for three months until he got a promotion. It wasn't until he slowed down a bit that he started to notice something was different about himself. He started to get irritable and says he "never slept". Once a police officer stopped him while he was driving because he had swerved to avoid a paper bag that was on the road which he "subconsciously thought was an IED"[86] (improvised explosive device).

[86] IEDs are the signature weapon of the Iraq and Afghanistan wars. They define a battlefield that has been described as "asymmetric" because combat is no longer just about one to one enemy combatants. This dynamic requires heightened vigilance in the battlefield.

> But what had happened was there was bag in the road. And I just didn't even think about it. I assumed it was an IED. I mean, subconsciously. I swerved to miss it. There was a police officer right behind me… And I didn't even tell him that. I told him I don't know. I didn't maintain my lane. I didn't want him to think I was crazy.

Next, he talks about his relationship with everybody in his life and how difficult he was becoming. "It got to the point where I was almost impossible to deal with." He describes losing his job due to his difficult behavior and violence. And he describes his "come to Jesus" moment as a talk he had with his friend's dad who was a veteran who told him that he needed to get some help from the VA. His demeanor changes when he talks about his moment, even the pitch of his voice:

> We were talking about the military and my service. He was in the Navy back in the day… And he was kind of telling do you have any problems? I said you know it's funny, I kind of do. And he was the one that told me you need to get with the VA. You need to go see somebody… And I was like, nah, I don't need that. He was like, you do… I'm telling you now you do. It's like he knew something I didn't because he had already been there.

The narrative then moves into its second act in which Reagan talks about being a different person than when he left for Iraq but trying to make the best of it.

> There's no doubt in my mind. I am not the same person I was before I left for Iraq… Now I came to a conclusion. I can either throw in the towel and fall to the wayside. Or I can get every bit of help that I can and become the best person I can be right now. … If it's going to be a struggle for me every day, then it's going to be a struggle. All I can do is go get the help I need.

Reagan admits the difficulties he was having in his relationship with his fiancé and how he suggested that she learn more about PTSD so she could better understand him. He talks about how they made the decision to go to counseling together at a vet center. "Her being supportive has made a huge difference. And everything is not perfect. We still have our struggles. But when you're educated to what's going on, it's a lot better." The video ends with him talking about how he initially tried to run away from the problem by staying busy and he turns what he learned in the process as advice for other veterans:

> You're going to run but you're going to get tired sooner or later, and that problem is going to be there. If you got an opportunity to go talk to somebody, you need to go do it. ... Go talk to somebody. Because whatever you're dealing with, you think you're the only one, you think I'm on this island all alone. There's a thousand more-people going through the same thing. And it will benefit you. It will benefit them to talk about it.

Reagan's closing thoughts make a case for the power of shared experience as a therapeutic source of support. The candor in his voice and his tone conveys empathy that is hard to put into words but is exactly the power of this form of communicative engagement. There is a subjectivity (or rather subject position) that he creates for viewers in the way that he delivers his own narrative that is meant for other veterans who, like him, may be denying they have a problem.

Reagan's story was posted on the MTC Facebook page on June 26, 2012 with the following text accompanying the post: " 'I'm not the same person I was before Iraq.' Hear Reagan's story of strength and connection." Framing his story as "strength" is part of a larger theme to re-frame what strength is among veterans. As a recipient of two purple hearts, Reagan has attained the highest recognition for valor and courage from the

military, which makes him an ideal messenger to re-frame what strength means. This post was shared 1869 times and liked by over 9,600 people. His story on the MTC YouTube channel has been viewed 110,031 times. Part of the innovation in the modular nature of the MTC campaign, with its various digital parts, a website, Facebook, and YouTube, are that each technology provides an opportunity to reinforce frames and emphasize the narrative VA has constructed to access treatment. With each connection the veterans are encouraged to make, the VA is creating social ties that bring veterans closer to the VA.

Trista's story

The next ad (Figure 12) features Trista who served in the Navy and US Army National Guard for 16 years. The main quote on the ad has a different focus from the others, that of "story". "It's amazing what you can do by just telling and owning your story." Her quote instructs that stories do things and the implied target of that action is the self - the telling of the story can be transformative. In the lower part of the ad, there is a banner of smaller images of Trista in uniform and with her husband. The summary of her story below the banner presets the VA's framing of her story:

> Trista served her country in the Navy, Marines, and Army National Guard and wants other Veterans to hear her story. She has overcome a lot - from military sexual trauma to arguing with her spouse. Now an advocate for other women veterans, she reached out for support and got her life on a better track. She made the connection. You can, too.

Trista's ad ran in *Money* magazine, which covers a range of personal finance topics for the general public, and *Southern Living*, a lifestyle magazine that targets those living in

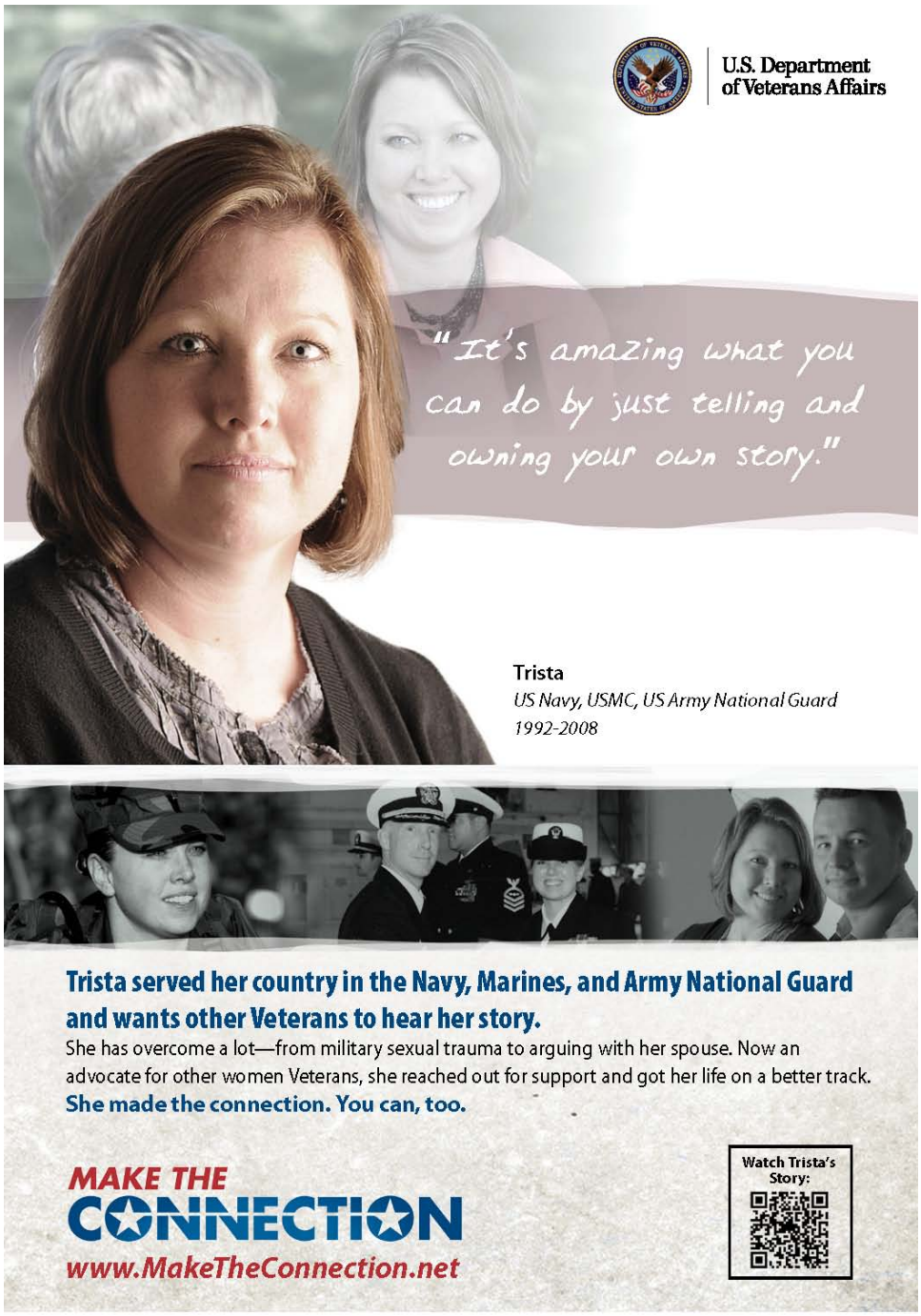


Figure 12, Make The Connection Print Ad, Trista

the south and features recipes, house plans, garden plans, and information about Southern culture and travel. Both are mainstream magazines with a wide circulation.

Trista's video story is titled "Leading and living strong after facing adversity". It begins with her husband Hector talking about how they met in the military and how her "character" drew him to her. Next Trista describes what it's like to be a woman in the military and the lack of respect that comes with this. Trista describes her experience with hazing, harassment, assault, and rape. Specifically, she talks about her own experience with military sexual trauma while she was in her officer candidate school in the Navy, how she got pregnant, and how she responded. She describes feeling isolated and violated: "The scary part about it is that we are trained that the guy to the left and to your right is your brother. Well, if it's your brother that's assaulting you, who are you going to tell?" She internalized this violation in trust and discusses her denial of what had occurred and how she had blamed herself. Hector discusses picking up signals that something was amiss when they would fight. But it wasn't until Trista started doing outreach work with other veterans that Hector finally found the right words to convince her to confront her own pain. She explains, "His favorite quote is you can only lead as far as you've gone. And you're trying to lead these women vets. And you haven't even been there. You haven't walked through the doors yourself."

The video then moves into its second act as Trista talks about going to the VA and talking with a psychologist about her military sexual trauma for the first time, which by that point had occurred ten years prior. It was also the first time she talked about how she got pregnant from that incident and the decision to keep her child. "I chose to keep my son. And Hunter is a special needs child. He's severely autistic and developmentally

delayed. And that came with some career choices. It's why I left the Marine Corps." Next her video highlights her work with women veterans who have had similar experiences. "I work with a lot of women vets. We meet for coffee. And we talk. And I hear story after story of experiences of military sexual trauma or PTSD. Sometimes they go hand in hand." Next, we see Trista sharing an emotional story about her platoon that brings her to tears and we see the other vets reach out to her. This moment is an example of her leading by example. By disclosing a tragedy that has befallen her and making herself vulnerable enough to cry in front of the group - she allows others to the same. She goes on to explain further, "Once you start talking to women vets our experiences are very similar. You've got this idea that it's people with a physical injury that need to go the VA. And it's not just about physical injuries." Hector then shares a profound insight: "The hardest conversation you'll ever have is the conversation you'll have when you take two steps forward, turn around, then face yourself." (Confronting yourself is a theme across all the stories that I will further unpack below in the final section of this chapter). The last part of Trista's narrative focuses on the role mental health care plays in keeping her entire family unit well and the importance of connecting to the VA. She closes with a powerful point: "We're so willing to sacrifice ourselves for others as veterans. But at some point, you have to look internally and just take care of you. It's all about talking. And it's amazing what you can do by just telling and owning your own story." Trista's story hit a chord. Her video has been viewed 432,690 times on the YouTube channel and her story was shared 5435 times and liked 105,000 times when it was posted on Facebook.[87]

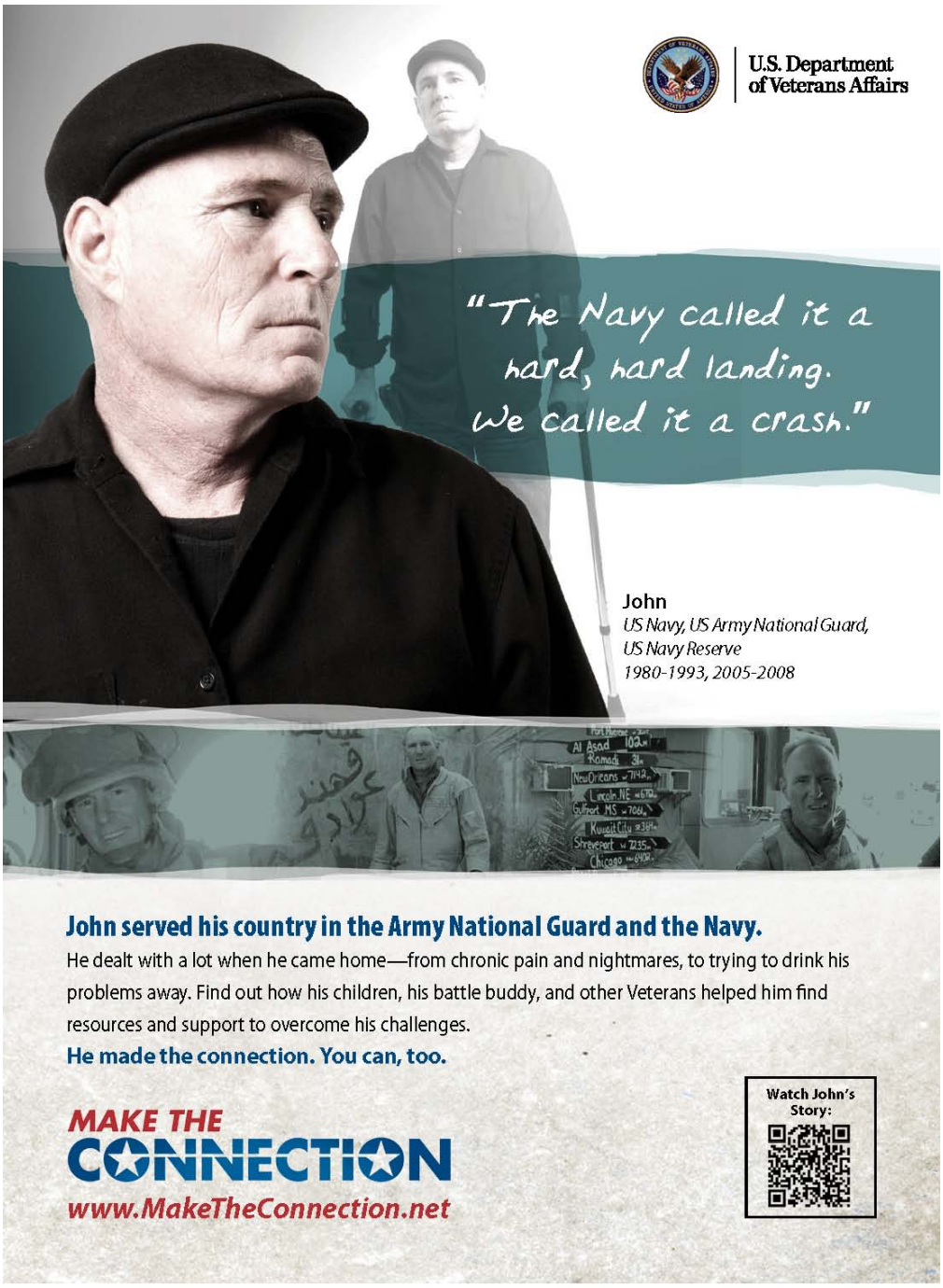
[87] Accessed April 12, 2018.

John's story

The next ad (Figure 13) features a veteran by the name of John who served in the Navy and US Army National Guard. This ad ran in the magazine *Popular Mechanic*. The quote that is prominent on this advertisement reads: "The Navy called it a hard, hard landing. We called it a crash." The picture of John is a side profile with another image of him, almost full body, in the background holding crutches. In the lower part of the ad there is a small banner of images of John in uniform while he was deployed. Below the banner, the summary of John's story reads:

> John served his country in the Army National Guard and the Navy. He dealt with a lot when he came home - from chronic pain and nightmares, to trying to drink his problems away. Find out how his children, his battle buddy, and other Veterans helped him find resources and support to overcome his challenges. He made the connection. You can, too.

John's video is titled "They called it a hard landing" and his story begins with him explaining how the crash led to chronic back pain in his life and that he was also eventually diagnosed with PTSD and residual brain injury. He goes on to describe what it means to live with chronic pain issues: "You just suck up the pain and just go on every day". John's demeanor makes these words even harder to hear. Unlike the other veterans in the prior videos, John's eyes never meet the camera's. His gaze is directed at the floor as he shares his story. He goes on to explain how he turned to alcohol to cope with his pain and PTSD. Next, he talks about other life factors that made it difficult upon his return. His father-in-law who he had known for 26 years died, he was going through a divorce, and then his mother died. He discusses these challenges and feeling like a "mess", "dealing with all that and PTSD and physical pain," while also having no



Popular Mechanics • Vietnam • John

Figure 13, Make The Connection Print Ad, John

community to support him. He describes moving in with his children as a turning point in his story that forced him to pull it together because he became a single dad and had to prioritize providing for his children. In the final act, he talks about his journey into the care system, how it took "the strength of a warrior" to access care, and the importance of getting a veteran or someone you can talk to when you do get in the system.

John's story, similar to the other stories, is about re-framing strength and the importance of having a community of veterans that support him. These are themes that re-occur throughout all the ads. John reverses the assumption that seeking care is a sign of weakness and explicitly states: "Don't think that it's being weak [to access care]. It's being weak not to reach out." He also specifically talks about the support he relies on from other veterans and the VA in the same breath as if to say they are one in the same: "It seems like vets still rely on vets, and the VA they're there. They're there to help us. … Our best support is each other. That's what I love about going to the VA... The vets help each other." His words reflect the way in which the voice of veterans in this campaign is collapsed as the voice of the VA. John's story was viewed on the MTC YouTube channel 54,520 times. It was posted on the MTC Facebook page, shared 775 times, and had 6,000 likes.[88]

Constructing the Vulnerable Warrior

All of the above stories are about accessing care and treatment at the VA and re-presenting VA to other veterans in the public sphere. Though they are not a

[88] Accessed April 15, 2018

representative sample, they do illustrate the beginning parameters of a new discourse the VA is deploying to re-frame mental health and in the process to re-present itself. These narratives have all been carefully constructed to show what seeking care looks like and to teach that recovering from mental health problems is possible. These themes fill an important gap, described earlier, that exists in the popular media's coverage of veterans' mental health issues; namely, that mental health problems can be treated and cured. Speaking about this campaign one VA staff member further explains:

> This is really new territory for the VA. This campaign is really different and unlike anything we have ever done. It's exciting and more importantly it is responding to something very important that I can only refer to as a "new stigma". With all the increased attention mental health problems among Veterans is getting in the press comes the added concern that all Veterans are problems. And of course they are not. This a chance for the VA to get in front of that. And show that there's treatment and help available.[89]

Positioning this campaign as a response to the misrepresentation in the press coverage of mental health issues among veterans that the "new stigma" is referring too, means that VA has started to take control of its representation in the public sphere through the use of these stories. I argue that VA's use of veterans' stories of accessing treatment services as a response to misrepresentation breaks new ground for the institution and allows it to gain a foothold on its own story in the public sphere and to start challenging the single story that has been manipulated for political ends.

In addition, taken together, these six ads also illustrate a new warrior archetype the VA is constructing which I refer to as the "vulnerable warrior." There are four

[89] Interview with Staff Member #8, July 23, 2016

common themes across the above stories, which I discuss below, that reveal the parameters of this new archetype. The first theme that emerges is a redefinition of strength. For example, Bryan talks about the difficulty that veterans have admitting any weakness or dealing with emotional stress because of the military training that has taught them they must be tough. He talks about how this training makes "you just suck it up." And then he goes on to reframe strength by talking about the courage it takes to go against the training he received and "admit that there's something broken inside of you." Instead of holding things in, strength is redefined as reaching out. Similarly, John talks about the strength it takes to reach out and how seeking care truly takes "the strength of a warrior…because it is very hard, and it takes a lot of strength to actually make the call". The explicit reframing of strength in these stories is further revealed by a closer look at some of the summaries that accompanied the ads or posts on social media. In the framing of Reagan's story as a post on the Facebook, the VA actually uses the word strength: "Hear Regan's story of strength and connection." Interestingly, Reagan never mentions the word strength. The closest he gets to it is when he talks about the choice between throwing in the towel or getting help and struggling "to become the best person I can be right now." Jack talks about a motivating source of strength for him which was the realization that the friends he lost in the war "were as old as they were going to get…And if they could talk they would say, hey, come on, you're living for me now." So strength is not only the act of reaching out, but it is also the awareness that one has an obligation to keep going for others who no longer have the chance.

The second theme that emerges is the importance of confronting yourself. A common refrain across the stories is that they all were not the same person they were

before they left for war and, at some point, they were going to have to confront this reality. The vulnerable warrior is someone who is willing to have, building on the words of Trista's husband, "the hardest conversation", by taking two steps forward, turning around, and facing him or herself about what war had done to them. Reagan talks about confronting himself and the fact that he tried to stay busy and run away from it but "you're going to get tired sooner or later and that problem is going to [still] be there." Nicole talks about confronting herself in the context of her family and how she could no longer ignore the voices of those of those she loved which eventually led her to deal with the problems she was having. Similarly, John talks about needing to be there for his kids as the primary driver for him to confront himself. In Trista's story, she could no longer continue to do her outreach work with women's veterans and lead others down the road of life after military service until she had first dealt with herself which ultimately meant accessing VA services for the first time. In all of these stories, "dealing with yourself" is synonymous with accessing VA treatment services and seeking care.

The third theme is the power of empathy as a pathway to treatment. All of the stories emphasize the importance of receiving help from others who have been in your shoes or who are willing to listen with an empathetic ear. What is interesting about this theme is that the VA is being positioned as a source of empathy. In Bryan's story, he very explicitly links the VA as the entry point to accessing a community of veterans who all want to help and are well-positioned to do so because they "have been in your same shoes, that know what you're going through, that have already overcome this." The VA has a history of mobilizing empathy-based care through the Vet Centers, as discussed in the chapter X. Peer-support has always featured prominently in the VA's model of care.

But the MTC campaign is moving this peer-support into new terrain by using veterans' video-based narratives as the currency of exchange. In essence, what the VA is doing by creating a database of over 400 stories is using media as a structural intervention that travels digitally to deliver its empathic form of peer-based care.

The fourth theme that emerges is the ways in which veterans' stories are being used to model healing behaviors for other veterans. Each of these veterans' stories shows other veterans what steps can lead them to seek care and includes advice about seeking care. The VA is ultimately trying to get veterans who hear these stories to do something - to access treatment. The stories are meant to inspire, motivate, and elicit action. The MTC campaign allows viewers to engage with the stories in the privacy of their homes and it is creating a community out of this experience by creating social ties through the exchange of these stories online. A closer look at the comments section of the MTC YouTube channel and Facebook website reveals a high level of engagement with the content presented in both places. The ways in which stories are used to create a sense of solidarity in the MTC campaign is well-positioned to address the hallmark of trauma which is dissociation. Exchanging stories and consuming them as gifts repairs the connections that have been broken by trauma. These stories create community which is evident from the sheer number of online supporters that are part of the MTC campaign and the high level of engagement with the content. Furthermore, creating a community from those who may feel disconnected and isolated is also a strength that media brings to this effort.

The VA's attempt to facilitate the imagination of the yet unseen and create future healed veterans who have yet to seek care sets a very creative precedent for health

literacy efforts that target veterans' temporal horizon. Part of what the VA is doing is helping people imagine a better future for themselves that is different than the pain and limits created by untreated mental health problems. Imagining this unseen future self is partly about remaking an identity, which anthropologists have called "cultural action" (Geertz 1997: 7), and in the process rebuilding moral agency. I argue that the stories that comprise the MTC campaign provide a pathway for rebuilding this moral agency that begins with redefining strength, confronting self, and honoring story. In so doing, similar to the military's Be All You Can Be, Make The Connection provides a pathway for those that have yet to seek care to find their future.

Taken together these themes construct the parameters for a new archetype - the vulnerable warrior. Anchoring this archetype is an understanding that no one is immune to the trauma of war and that it takes real strength to confront yourself and seek care. The vulnerable warrior is aware that he/she has limits that can be broken and is not afraid to say so. This new archetype is a cultural representation of a warrior that is inherently political because acknowledging that warriors are not invincible calls into question the cost of war.

The former Secretary of the VA Max Cleland draws this connection even closer: "If you want to fix the problems at the VA, then have no more wars." Speaking at a VA Suicide Prevention conference he further explained the problematics of war.

> War … can take away parts of your body. And I know that, many of you know that. It can take away your sense of justice, your sense of safety and a number of other things with which you have to deal. Now the good news now is that no Veteran from any war in America has to deal with those issues by themselves anymore (Cleland 2010).

Cleland, a Vietnam veteran himself, describes the ways in which war takes veterans to the far ends of human experience and may eventually break them. The title of his memoir, *Strong at the Broken Places,* which chronicles his own journey of recovery comes from Hemingway's *A Farewell to Arms*: "The world breaks everyone and afterwards many are strong at the broken places." And for others who travel to that edge and do not break, there are physical, mental, and moral losses that must be confronted upon returning home.

The VA must attend to these vulnerable warriors and their losses which has a cost that goes way beyond the federal budget. In fact, there is no mechanism in the federal budget to pay for the long tale of what it costs to take care of veterans because from past wars we know that the peak year for benefit payments has a very long tale (Stiglitz and Bilmes 2008). For example, the peak year for benefit payments for WWI veterans was 1969, more than 50 years after the war. The peak payment for care of Vietnam veterans is still climbing and will continue to do so for 20 years (Burns 2016). The current estimate for what it will take to care of the vulnerable warriors of the post-Vietnam and post-Iraq Veterans is a trillion dollars (Stiglitz and Bilmes 2008). And there is no mechanism to allocate this money in advance of war. "So if you can't take care of them, maybe you shouldn't send them" (Cleland in Burns 2017). And therein lies the political dilemma.

Visual Medicine: Visual Media as a Structural Health Intervention

The VA's use of video-based narratives of veterans' personal experiences with trauma and readjusting to civilian life establishes a new precedent for the way the

institution communicates about itself as well as how it does outreach to veterans. This new form, with its modular design that is characterized by differing adverse experiences, has unique properties that make it well-suited to address the fragmentary nature of trauma. Since the "hallmark of trauma is dissociation", healing from trauma necessitates making a connection, first to self and then slowly to others (Bloom 1997:249). The form the MTC campaign has taken, multiple stories and voices woven together into a unified whole, is itself a metaphor for piecing the fragments together.

Each of the stories in the MTC campaign, taken individually, are moving. But the real power of these stories lies in the collective tapestry of voices and shared experience that places all the adverse illnesses and experiences veterans face (PTSD, OCD, TBI, military sexual trauma etc.) on equal footing. When viewed as a collective the common variable becomes the struggle to live a life that is not interrupted by these experiences. This makes the MTC archive of stories a collective cultural product about survival. The collective yet modular design of the campaign is an impressive innovation that makes a compelling case for using visual media as a structural health intervention that targets cultural barriers to seeking care. I refer to this use of visual media as a structural health intervention, "visual medicine".

The MTC campaign is an expression of visual medicine. Drawing on this example, visual medicine targets the cultural barriers to seeking care by correcting misrepresentations about who warriors are. Visual methods that employ video can begin to capture "those aspects of culture which are least amenable to verbal treatment" (Bateson and Mead, 1942). In the context of MTC, giving voice to aspects of culture which are least amenable to verbal treatment means confronting the stereotypes that make

it difficult for people to access care. Building on this example, at its core, visual medicine is political because changing representations about cultural barriers to seeking care are about changing what is seen as true and perhaps the only truth. The MTC campaign also acts as an intervention to correct the stereotypes about the VA that have circulated in the public sphere. By telling the stories of veterans who have successfully recovered, the VA is claiming the healing stories about itself that should circulate alongside the narratives of failure. This helps VA gain a foothold of its representation in ways that position it on the same side of the line as veterans.

In conclusion, the effort to populate the public sphere with a new archetype of the vulnerable warrior and an alternative story about the VA involves a cultural struggle that hinges on representation. What is at stake is the hegemony of the warrior myth, the dominant transcripts that soldiers are invincible and the narrative that public forms of health care will always fail. In a world where the archetype of the vulnerable warrior has gained a foothold, the question of military readiness - willingness and ability to send soldiers in harm's way - and military recruitment looks very different. If it is popular knowledge that warriors can break, how do you convince people that they should enlist anyway? In a world where publicly funded health care works, who benefits by saying the VA always fails?

CHAPTER 6

CONCLUSION: SCANDAL AND STRUCTURAL NONVIOLENCE

In the final chapter, I return to the initial premise of this dissertation which was to study health policy formation as a cultural process in the hopes of better understanding why the practice of making health policy sometimes lends to the VA's failure to meet veterans' needs. Failure at the VA is often expressed as a scandal. Scandals in government are moral tales (Stevens 2016) about corruption. The core of this often public spectacle is anger directed at betrayals of public trust. Legal scholars have defined corruption in government as "excessive private interests in the public sphere; an act is corrupt when private interests trump public ones in the exercise of public power, and a person is corrupt when they use public power, for their own ends, disregarding others" (Teachout 2014: 9). Scandal has an odd durable quality at the VA that dates back to the inception of the institution (see Appendix 1). "Scandal, controversy, and veterans care in the United States have gone hand-in-hand for virtually as long as there's been a republic" began a CNN article about "VA's troubled history" (Pearson 2014).

The media often reduces the scandals at the VA to bad actors but scholars have refuted this claim by arguing that simplifying it is politically useful for liberals who complain about the defunding of social services as well as conservatives who use this as yet another example of a government bureaucracy that has failed and who in particular want to make sure government has nothing to do with health care (Burns 2017). But what is it that scandals do and how does this relate to the health policy formation process? To

answer this question, I explore the 2014 wait time scandal that led to the resignation of Secretary Eric Shinseki. A scandal that occurred while I was observing the VA.

Wait Time Scandal

In 2014, it was discovered that the Phoenix VA falsified data about waiting times for veterans seeking care in order to cover up the fact that veterans were waiting much longer than the standard VA had established for good care. The Inspector General (IG) report showed that the VA was actually manipulating the data by hiding waiting lists. More specifically, 1700 patients were not placed on the official waiting list for medical appointments and may have ultimately never received care (VAOIG 2014). The IG report also revealed that the actual waiting times that the VA was attempting to cover up, 115 days, were almost five times higher than what was actually reported. How did a transformation that began with the goal of standing on the same line as the veterans, end like this?

When the initial standard of two weeks was set, for the longest a veteran should have to wait to see a physician, there were people within the VA that were familiar enough with the shortage of primary care staff across the country, even beyond the VA, who were concerned that the resources had not been put in place to meet this standard. Primary care doctors are the main entry point of care in the health care system, and the shortages, especially in certain regions of the country, was well documented (Kaiser Family Foundation 2018). This shortage meant that access, even beyond the VA, was partly a structural issue related to understaffing of health care professionals. Therefore to enforce a standard of 14-days it would mean that there would have to be an expansion of health care staff hired to meet that standard, particularly in parts of the country where

primary health care workforce was particularly short-staffed. But the VA set the standard anyway and those within the bureaucracy that had reservations were not part of the senior staff, mostly Senior Executive Service (SES), who were making the major decisions under Secretary Shinseki. The SES staff had a particularly elevated status in Shinseki's administration and their status was partly tied to where they came from – the private sector.[90] What this meant was that it was more difficult to refute their ideas – even if they were bad. I had sat in on several meetings where this was the case. So when it came to figuring out how best to meet this new standard, a common private sector solution of tying bonuses to standards was implemented. More specifically, the VA provided bonuses to administrators who could reduce veterans' wait times for doctor and hospital appointments. But without fixing the underlying structural problem, the actual wait times for appointments continued to lengthen and anyone who said there was a problem was met with anger.

> I think the larger problem was cultural… it was a very punitive culture. I tried to raise the fact that field offices were having problems several times, often with senior leadership in the room. And at least on the VHA side, they silenced me. Even in front of the Secretary. There was no room to say that without a blowback. The leadership had a style that made it very difficult to constructively deal with the problems of transformation which meant at certain level, leaders were not willing to acknowledge problems. All they wanted to do was paint a rosy picture. There was really in some sense a punitive culture for any facility where there was a problem. It wasn't let's help Phoenix figure out how to get more resources. It was punitive.[91]

[90] Staff interview #9
[91] Interview with Staff Member #11, August 10, 2016.

The characterization of the leadership style at the VA as punitive, was something that I heard a lot in interviews and one particularly senior manager was particularly punitive in his approach was raised several times. This led to a situation where people in the field began gaming the system because of the pressures of a "front office getting very upset" (Prentice 2017). Waiting lists were manipulated so that VA administrators still received their bonuses. When you strip back the layers of this scandal, the root actually had to do with the structural limitations in the capacity of the health care system, an "audit culture" (Strathern 2000) of performance metrics that had created perverse incentives for individuals to game the system, and a bureaucracy who senior staff had a punitive leadership style. But the story in the media did not delve into these details. Instead, once again, the VA had proved to be corrupt.

The irony is if we take a step back and look at the landscape of health care delivery, the practice of corruption in health care is actually quite extensive – it is certainly not unique to the VA. The excessive private interests that drive the for-profit corporate medical system, a system that many have argued should protect the public's interest, is at odds with the obligations that providers may have. Health insurers and private hospitals have a legal obligation to their shareholders while physicians have legal and ethical obligations to their patients, and therein lies the dilemma. Protecting, securing, and ensuring the profits made by market-based medicine remain high is why corporatized medicine has been described as a "uniquely American gold rush" (Brill 2010) with itemized bills from hospital stays revealing markups as high as 400% on medications used in the hospital. Furthermore, the way the medical community in these for-profit systems treat patients has been compared to "the way subprime-mortgage

lenders treated home buyers: as profit centers" (Gawande 2009). Yet, even in the face of these predatory practices, when compared to the VA, the cultural legitimacy of private sector medical care is often positioned as being the solution to access issues in the VA and more legitimate. I argue that what in fact scandal does at the VA does is ultimately mask the business as usual predatory practices in the private sector medical care system and bolster its legitimacy as a viable solution to fixing the VA.

Understanding scandal from this perspective shifts the conversation about why VA is failing away from corruption to underlying structural factors. It becomes clearer to see that the two million new veterans that have entered the system (CNN 2014) since the Iraq and Afghanistan wars have stretched the VA's structural capacities as a health care system and that directing the state to enter these veterans into the private sector care system, which proponents of privatizing the VA have suggested, would not change the underlying structural issue of access. So then the persistence of reducing VA scandals to simply corruption is ultimately about a deeper battle about the role of the state in issues of care and external forces that are fighting for the soul of health care in America. When health care becomes the grounds on which failure of government obligation is understood, the state fails its ultimate political test: take care of the very people it explicitly has promised. So what scandals do in this instance is reconstitute the state as being an archetypal example of a bureaucratic failure. It prevents the state from having any radical potential. The politics of scandal in this context is about creating an order where the VA's subject position is created, maintained, and reproduced to *not* be political. By "politics" I mean it in the sense that Ticktin has described as being different from the "political". Ticktin writes: "'Politics' refers to everyday politics, often to policy

- that is, the set of practices by which order is created and maintained" (2011:19). Whereas, the "political", Ticktin writes, "refers to the disruption of an established order" (2011:19).

In contrast, the health reforms discussed in the previous chapters reveal a common political theme: health policy formation is an entry point for the state to reconstitute itself in ways that disrupt conventional notions of what it is. The examples of health reform discussed in prior chapters call into question the state as a supremely rational bureaucratic form that only inflicts harm on its subjects. This begs the question: what vision of the state does taking care of heroes during the tenure of Secretary Eric Shinseki create?

Reimagining the State

Health systems like the VA have been described as "core social institutions" because "they function at the interface between people and the structures of power that shape their broader society" (Freedman 2005: 21). Similarly, the VA is a "core social institution" that defines experiences of citizenship for veterans in ways that both reveal America's ambiguity about the obligations owed to individuals by the state and challenge notions of what the state is.

In the previous chapters, I reviewed examples of health policy reforms the VA instituted under the leadership of Secretary Shinseki. These reforms were begun as a part of a massive effort to transform the VA during the Obama White House so that it could better meet the needs of veterans. But these reforms were also a form of statecraft that repositioned the state in disruptive ways that challenge a monolithic narrative about the

state. In the case of the Blue Button, the Agent Orange decision, and Make the Connection – the state looks different than conventional understandings allow. The history of the VA shows there is precedence for the institution redefining what the State means.

As reviewed in Chapter Two, it is clear that the VA evolved a system of care for wounded soldiers because there was broad political consensus that wounded soldiers were deserving of care. In order to meet these demands, General Omar Bradley, who was Secretary of the VA from August 15, 1945 to November 30, 1947, is credited with modernizing the infrastructure of the VA by introducing alliances between the VA and leading medical schools across the country. This alliance paved the way for the VA to become a backbone for medical research and the training of physicians and allied health professionals. The VA's involvement in medical training and research positions reconstitutes the state as a pillar of professional education and innovation. The fruits of the medical research that VA has led has benefited all Americans not just veterans by transforming standards of medical care. For example, the finding that one aspirin a day reduces cardiac mortality by half; the development of the nicotine patch to help smokers quit; conducting the first successful liver transplant; pioneering the concepts that led to CAT scans; invention of implantable cardiac pacemakers; and identified a gene associated with a risk to develop schizophrenia, to name a few.[92] The list of medical advancements are truly astounding (see Appendix L) and have changed the landscape of care in America and led to multiple Nobel Prizes and Lasker Awards for discoveries that range from discovering leukemia-and cancer-causing viruses to the development of

[92]Accessed February 1, 2019. https://www.research.va.gov/about/history.cfm.

radioimmunoassay as a technique for measuring various substances in the blood.[93] These accomplishments re-position the state as a site of medical innovation and advancement.

Similarly, the new Agent Orange presumptions discussed in Chapter Three re-position the state as a site where scientific causal claims are questioned. This challenges understandings of the state and governmentality that ally the rule of experts with the rule of government (Barry, Osborne, Rose 1996; Rose and Miller 2013). The legacy of Agent Orange decisions have a pattern in that the effects of Agent Orange were often discovered after veterans had died. This pattern is connected to the lag in time between scientific studies being conducted about Agent Orange and the VA acting upon this information. This pattern has meant that veterans have died waiting for science to catch up to their reality which produces structurally violent outcomes in that the process itself is what is flawed. In this context, Shinseki's decision to follow the letter of the law and relegate scientific causality secondary to the legal standard set by the Agent Orange presumption legislation created a way for the system to be nonviolent. In this particular example the state, which has often been positioned as being constitutive of expert knowledge, was actually more concerned with doing what was just. In the setting of the VA, doing what is right by veterans is the goal, but policies, procedures and bureaucracy can too often get in the way. But as the Agent Orange example instructs, policy can be used to enable justice to enable just outcomes through the subversion of the bureaucratic process itself. Using policy to create nonviolent spaces within the bureaucracy, spaces that are no longer "dead zones for the imagination" (Graeber 2015) is what I refer to as "structural nonviolence". Graeber defines the structural violence of bureaucracy as an "emptying out of any

[93] Accessed February 1, 2019. https://www.research.va.gov/about/history.cfm.

possibility of communication or meaning" (2015:102) and what I am naming as structural nonviolence attempts to restore what has been emptied out. In the case of the Agent Orange presumption, the ability to acknowledge that despite scientific causality standards, there is evidence that suggests with time a threshold will be met that tips the balance towards causation prevents a "structurally stupid" (Graeber 2015) outcome. Thus considering the relationship between policy and justice in a large health bureaucracy like the VA restores meaning back into health policy formation in ways that create structurally nonviolent possibilities. In contrast to the theory of structural violence which has been a cornerstone in the medical anthropological literature, structural nonviolence is an analytic lens grounded in the health policy solutions that have the potential to alleviate suffering instead of just understanding it. Structural nonviolence is a pathway for pushing thinking about health beyond the suffering of individuals and locates the power to impact the multiple determinants of health in the bureaucratic structures that shape them.

The VA's role in potential creating structural nonviolence repositions the state as a nonviolent actor which runs counter to decades of research. The possibility that the state can care for people instead of killing them is connected to democratic ideals of what it means to govern. The competition to give also deserves special mention in that the agonistic nature of policy formation reveals that recognition and the ability to police who contributes to the policy arena positions the state as a site where the ability to contribute cannot be taken for granted. Thus my finding shows that that democratic ideals concerning the ability to participate in political action can be limited in practice.

In Chapter Four, the introduction of the Blue Button in the public sector which led to rapid private sector adoption repositions the role of state as a potential source for

innovation and guardian against proprietary health information technology (HIT) standards that have obstructed patient access to health information. VA's adoption and promotion of the Blue Button was a trojan horse for ushering in the use of open source software in HIT – a private sector industry that has been dominated by proprietary solutions. VA's leadership in this domain represents an attempt to set a new standard for accessing health information that is not dependent on commercial market-driven solutions. This move untethered access to health information from its commercial core and repositioned access to health information as a right that was non-commoditizable. This was a highly disruptive position to take at a time when Meaningful Use laws as they relate to HIT were compelling health care systems and private practitioners to adopt commercially available HIT solutions. The disruption the VA created in the HIT market raised valid questions about who owns health data in ways that revealed the problematic practice of trapping health data and the paralyzing consequences that never-ending discussions about "standards" can and have had to action. By placing the emphasis on data liquidity and unfettered access to health information the VA shifted the conversation about access to its structural roots.

VA's guardianship in this domain also repositioned the state as a buffer to the market. In this context, the market makes it difficult for veterans, and other patients, to have access to their health information. So VA's effort to create open source solutions like the Blue Button that circumvent this market failure highlight a role for the state to may play in limiting the power of the market and the reach that it has on the forms that access takes. However, as the decision to discontinue the Blue Button Connector, the

effort to promote Blue Button expansion, demonstrates, the market can be a formidable force that has its own effects on government.

In Chapter Five, interestingly, the construction of who a warrior is in public culture becomes the grounds for the VA to wage a very different battle in representation, one that uses the voices of veterans it serves to re-construct its own relationship with its constituents. In this example, the state draws on veterans stories, and more precisely, veterans' autobiographies and co-constructs and distributes them as an intervention. How does this reconstruct the state? These stories about private citizens become fused with the state. The state uses these stories to influence and extends its reach into matters of daily life and into the private lives of veterans who have yet to make a connection to the VA. The allying of private lives with the VA blurs the distinction between civil society and the state, which anthropologists have long observed are not so separate, and reflect how the domains operate as a "knot of tangled power relations" (Crehan 202: 103).

Turning Justice into Policy: the Quest for Just Health

In all of the examples of health policy formation I have reviewed, the VA reconstitutes the object of the state as a potential site for radical action. As "the nation's largest health care system and the principal model for publicly funded health care reform" (Yano, Bastian, and Bean-Mayberry 2011:S74) being disruptive means challenging the established order that dominates corporate for-profit medicine. The first Secretary of the VA under President Trump, David Shulkin, took a defiant stance to for-profit medicine efforts to privatize the VA and claimed that privatizing the VA was "a political issue aimed at rewarding select people and companies with profits, even if it

undermines care for veterans" (Shulkin 2018). If efforts to privatize the VA succeed, the encroachment of for-profit medical care will represent an entry point, by no means the only one, for the corporatization of the state. With 20% of the national's GDP being spent on health care spending, and most of this spending occurring in private for-profit medical systems, the costs of privatization cannot be overstated.

Anthropological critiques of market-based medicine have characterized a "fundamental conflict between what is just and what is profitable" as "the heart of what is wrong with health care in the United States" (Rylko-Bauer and Farmer 2002: 476). In the VA system of care health care is a right, an entitlement as opposed to a business. In the for-profit health care system, health care is a commodity. The cultural standards of legitimacy could not be more different. In the VA, physicians are salaried professionals that are not operating as independent entrepreneurs who are accountable to their shareholders. In this way, VA presents a formidable challenge to the legitimacy of for-profit medicine at a time at a time when the old fee for service model[94] that had been a driver of profit growth has lost its legitimacy.

Thus the inhibitory influence of the VA on the system at large lies in setting an altogether different standard for the structure of the health care system that is centered on justice. I argue that this orientation creates the potential for structural nonviolence within the bureaucracy of health care is one way to turn justice into policy in the quest for just health. "Policies can serve as instruments for consolidating the legitimacy of an existing

[94] Fee for service was the dominant mode of reimbursement in the American health care system whereby physicians would be paid by the volume of service and not the outcomes. Fee for service was thought to have driven up the cost of care and increased waste in the system.

social order or they can provide the rational for 'regime change' and the subversion of an established order" (Shore, Wright, and Pero 2011 :3). The politics of health care have largely been about the former: consolidating the legitimacy of an existing social order that denies medicine is a big business. However, what the Blue Button, the Agent Orange presumption decision, and Make the Connection do is open up the possibility for the VA to be structurally nonviolent and in so doing help turn health policy into justice. Paul Rieckhoff, Founder and Executive Director of the Iraq and Afghanistan Veterans of America and an army veteran himself, said the VA represents "the ultimate political test" (Burns 2017) which I argue is whether or not government can do the work of care. The previous chapters show that when this work is done in ways that hold justice central, not only does the state do the work of care, it repositions itself in ways that create new configurations and assemblages that facilitate the conversion of justice to policy. This translational power builds on a legacy of transformation in the VA which has spanned the roll out of new technologies, like the first electronic medical record, the spread of new models of care, and the active integration of lessons from research into evidence-based practice and policy (Yano, Hayes, and Wright 2010).

Population Health

My findings also make a contribution to the literature on population health by addressing the issue of accountability. The literature raises the question of who should be responsible for population health and has framed it as a "challenge of attribution" (Gourevitch, et al. 2012). All of the cases I discuss expand the boundaries of care beyond medicine and highlight VA's formidable capacity to implement public health programming. This makes the case for why responsibility to govern population health lies

with the bureaucracies that can implement programming that goes beyond the delivery of medical care. This makes a constructive intervention in the literature on the structural and social determinants of health which has often positioned medical systems as loci that have the power to influence population health outcomes.

A second contribution my findings make to this literature is also to make a case for why the state must share responsibility for population health. A structurally nonviolent state, one that has the imaginative and creative capacity to roll out media initiatives as structural health interventions and create innovative solutions that are replicated in the private sector is a state that can be responsible for the population health of its citizens and more importantly can do the work of care. This vision of the state is guided by an ethics of care that rejects violence and domination (Held 2006).

Anthropology of Mass Media

With respect to the literature on the anthropology of mass media, my description of "visual medicine" as a structural intervention positions the making of health-related media in the VA as a form of mediation between veterans and their potentially future healed selves while also extending the VA into the public sphere's representations of who a warrior is. Both uses make contributions to the literature. The cultural mediation work that film and video does pushed the literature in the anthropology of mass media and visual anthropology beyond formalist projects concerned with film as text (Ginsburg 1991, and Morris 2000) and shifted the focus from cultural form to process (Boyer 2012). My contribution to this literature is to show how VA's use of visual medicine exemplifies potentially new terrain for media to change the relationship that people who view it have

to themselves in therapeutic ways. Visual medicine as visual life stories (Linde 1993) that people must watch to heal also makes a contribution to the literature on narrative medicine (Charon 2006) which has been exclusively concerned with the ways in which narrative operates in the clinical setting alone.

This case also expands understanding about the way the state uses media. Commonly held assumptions about the relationship of media to state power align it tightly such that media is a tool for the expression of power and control (Ginsburg, Abu-Lughod, and Larkin 2002; Klinenberg 2007). But visual medicine, in the way that I describe it, opens up the possibility that the making of the media itself can be a form of power over the state that changes what the state is. In a structurally nonviolent state, the making of media itself can be a radical act that disrupts the relationship that consumers of media have with the state.

Political and Moral Economy of Health and Notions of Governmentality

My findings also make several contributions to the literature on the political and moral economy of health. The first contribution I make shows that health policy formation is an interactional achievement. Multiple stakeholders, bureaucrats, experts, and in the case of the Blue Button, private sector and nonprofit partners and an institutional bureaucratic context shapes what a health policy outcome can be. This conception of the health policy formation process, as an assemblage of many interconnections that often include very powerful groups of people and can have far-reaching effects that impact all of us by shaping the forms in which new health models,

innovations, and advancements occur delivers on the promise of what studying up can afford as initially conceived by Nader.

The second contribution I make to this literature expands upon Nader's call to study up. In the decades since Nader's call to study up, many have interpreted her efforts thinly – as an effort to study elites. But it is much more than a call to reverse the gaze up.

> As Hugh Gusterson has noted, studying up is more than a simple call to study powerful groups and individual – it entails 'hybrid research and writing strategies that blur the boundaries between anthropology and other disciplines' and 'offer[s] the chance to incite new conversations about power in the U.S.' as part of a 'democratizing project' examining the interconnections between the rich and powerful and the rest of us.(Gonzalez and Stryker 2014:13).

Although Nader mentions bureaucracy in her original formulation of studying up, through excerpts from her student's preliminary work, she does not delve into the details of bureaucracy (Nader 1974). But I argue that studying the administration of health care bureaucracies is a paradigmatic area to renew her call and restore its complexity. Her statement "never have so few, by their actions and inactions, had the power of life and death over so many members of the species" rings particularly true for health care bureaucracies and the administrators of health insurance companies who now determine, in many ways, who lives and dies. Furthermore, studying up in this context provides a chance to restore issues of scientific adequacy, democratic relevance, and the energizing effects of indignation that Nader initially cited as the primary reasons for why studying up was important. It is impossible to understand the poor health outcomes of Americans, as compared to other industrialized nations, without studying up. Thus the scientific

adequacy of the public health literature that attempts to do so will always miss important structural elements. In addition, as I have highlighted, issues of fairness are integral to conversations about health care delivery, particularly in the context of veterans, and veterans' protests remind us that advocating that the state take care of its veterans is an American tradition. All of these reasons explain why I describe the study of health care bureaucracies as being paradigmatic for studying up. Another reason, and perhaps the most obvious, is that the administration of health care is a multi-billion-dollar business which is why "the healthcare industry spends more on lobbying than the defense, aerospace, and the oil and gas industries combined" (Weissman 2016). This is a particularly formidable expression of power whose forms and influences should be traced to better understand how best to disrupt it as well as how its interconnections affect us all.

Ultimately this is what the VA affords. Studying health policy formation at the VA provides a vision of the state and a vision of health care that disrupts this power. It also presents health care administration as a potential rich frontier to rethink bureaucracies as institutions that have the potential to center an ethic of care. Held has described "the central focus of the ethics of care as being "the moral salience of attending to and meeting the needs of the particular others for whom we take responsibility" (Held 2006: loc 79).

The third contribution I make to this literature demonstrates what governmentality can be produced when the state centers an ethic of care. This observation makes a contribution to the literature on governmentality by allying the use of expert knowledge to concerns of justice instead of antipolitics. In the literature on governmentality, the technical elites are positioned as removing social problems from the political context and

casting them in the neutral language of science similar to the way that Foucault discussed the use of political technologies in concealing power (Dreyfus and Rabinow 1982). Thus the use of expertise has been viewed as a constitutive element of governmentality "for governing in a liberal democratic way" (Rose and Miller 2013: loc 587). But my findings show that the power of expertise can be limited and perhaps even suspended to open a different path for governance to take within a bureaucracy – a path that is morally response to concerns of justice and grounded in an ethic of care. If, as Graeber writes, "bureaucracy has become the water in which we swim" (2015: 4) then imagining what a nonviolent bureaucratic state can be is critical for government to do the work of care in a morally responsive manner. Jackson has argued "morality is not simply a question of one's good intentions; it is a matter of at least two people's moral responsiveness to each other and of the good or harmful repercussions of any action for both oneself and others" (Jackson 2016 :3). A morally responsive state forms health policy that centers justice. With the passage of the Affordable Care Act, the American state took ones step closer to this vision by extended itself into the work of care and in so doing it influenced the health care market by setting standards for fair play that outlawed unjust practices that allowed insurance companies to cherry pick coverage for only healthy people. But this same legislation has also encouraged the expansion of high-deductible plans with problematic assumptions of personal responsibility that the private sector brings with it. Thus, as health reform continues it is important to renew the importance of the state in mediating these discussions so that the forms that health reform takes looks more like what the VA does when it is operating at its best.

Conclusion

If the concept of citizenship is the most conventional way the relationship between the individual and the state is understood, veterans constitute a form of privileged citizenship due to the entitlement to services and forms of care they receive. I have argued that studying the way America takes care of its heroes provides insight into the fraught nature of what obligations the American state has to individuals while disrupting notions of what the state is. Policy formation can either uphold the existing legitimacy regarding the status quo as it relates to the care of veterans or it can create a new reality for what care should and can look like that changes the standard of medical care for the country at large. The VA's power lies in its ability to do the latter. The healthcare industry is a tough structure to reconfigure because its structure is partly determined by the needs of the for-profit medical system and powerful brokers that lobby on its behalf. Against this backdrop, the system of care within the VA is an expression of public control over the structure of health care that exerts a very necessary restraint that influences what the future of health care in America will be by providing an alternative cultural standard for legitimacy.

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APPENDIX A

VA OFFICE OF MENTAL HEALTH SERVICES PROGRAMS

- Post-Traumatic Stress Disorders (PTSD) and Returning Veterans
- Recovery and Rehabilitation
- Women's Mental Health
- Substance Use Disorders
- Integration of Mental Health and Primary Care
- Evidence-based Psychotherapy
- Geriatric Mental Health
- Telemental Health
- Suicide Prevention
- Homelessness
- Residential Care Services
- Veteran Justice Outreach Services
- Community Mental Health Coordination
- New Technologies/Informatics
- Monitoring and Evaluation Centers
- Other Field-Based Centers

APPENDIX B

SUMMARY OF FOUR POLICY PRIORITY AREAS FOR PSD-9

1. Enhancing the well-being and psychological health of the military family,
    a. By increasing behavioral health care services through prevention-based alternatives and integrating community-based services;
    b. By building awareness among military families and communities that psychological fitness is as important as physical fitness;
    c. By protecting military members and families from unfair financial practices and helping families enhance their financial readiness;
    d. By eliminating homelessness and promoting home security among Veterans and military families;
    e. By ensuring availability of critical substance abuse prevention, treatment, and recovery services for Veterans and military families; and
    f. By making our court systems more responsive to the unique needs of Veterans and families.
2. Ensure excellence in military children's education and their development,
    a. By improving the quality of educational experience;
    b. By reducing negative impacts of frequent relocations and absences; and
    c. By encouraging the healthy development of military children.
3. Develop career and educational opportunities for military spouses,

a. By increasing opportunities for Federal careers;

b. By increasing opportunities for private-sector careers;

c. By increasing access to educational advancement;

d. By reducing barriers to employment and services due to different State policies and standards; and

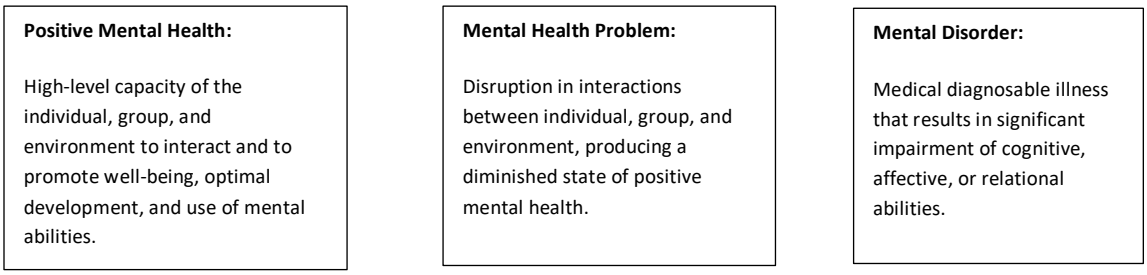
e. By protecting the rights of service members and families.

4. Increase child care availability and quality for the Armed Forces,

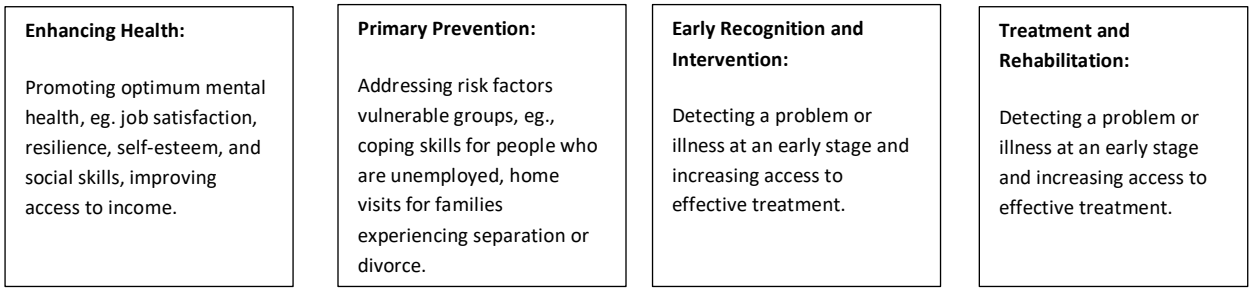
    a. By enhancing child care resources within the Department of Defense and the Coast Guard

APPENDIX C

MENTAL HEALTH STATUS AND CARE CONTINUUM



Mental Health Status Continuum



Mental Health Care Continuum

APPENDIX D

PRE-DECISIONAL DRAFT OF VISON STATEMENT FOR SUB-IPC ON PSYCHOLOGICAL HEALTH[95]

STRATEGIC OBJECTIVE: Maintain Behavior Health of Military and Veteran's Families at or above the of the national norm

CONCEPT: When you save a family you save their service member.

- Acknowledge that military families can become the first victims of the effects of deployments on the service member's behavioral health.

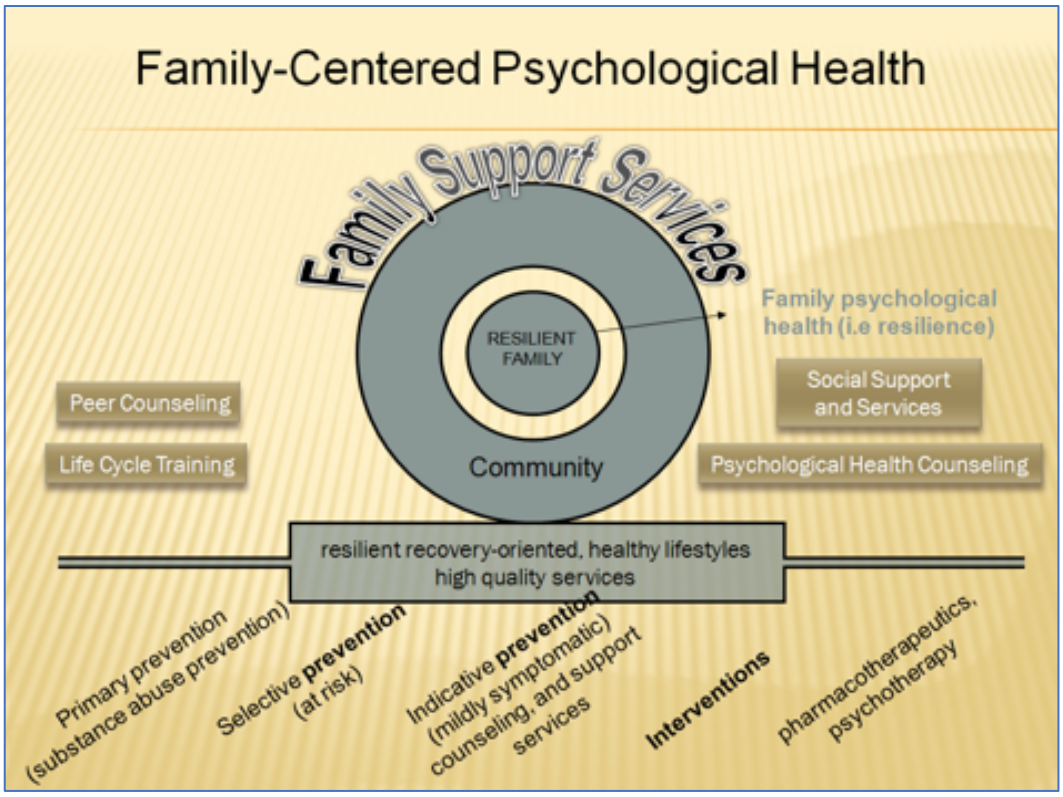
- Defines Behavioral Health as a broad scope of human encounters that incorporates and seeks to preclude mental health issues.

- Recognize family resilience and evidence based behavioral health practices are inseparable, including the use of peers at each level of organization and service.

[95] Primary document

APPENDIX E

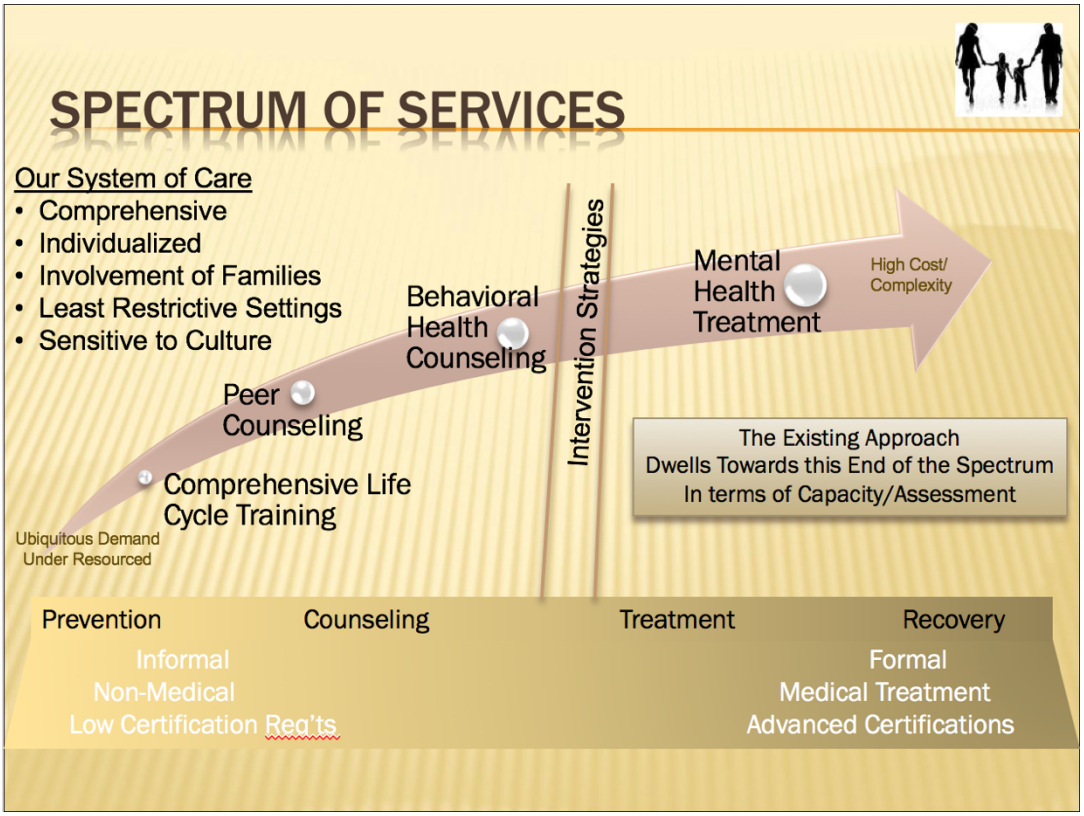
IPC PSYCHOLOGICAL HEALTH DIAGRAM[96]



[96] Primary document

APPENDIX F

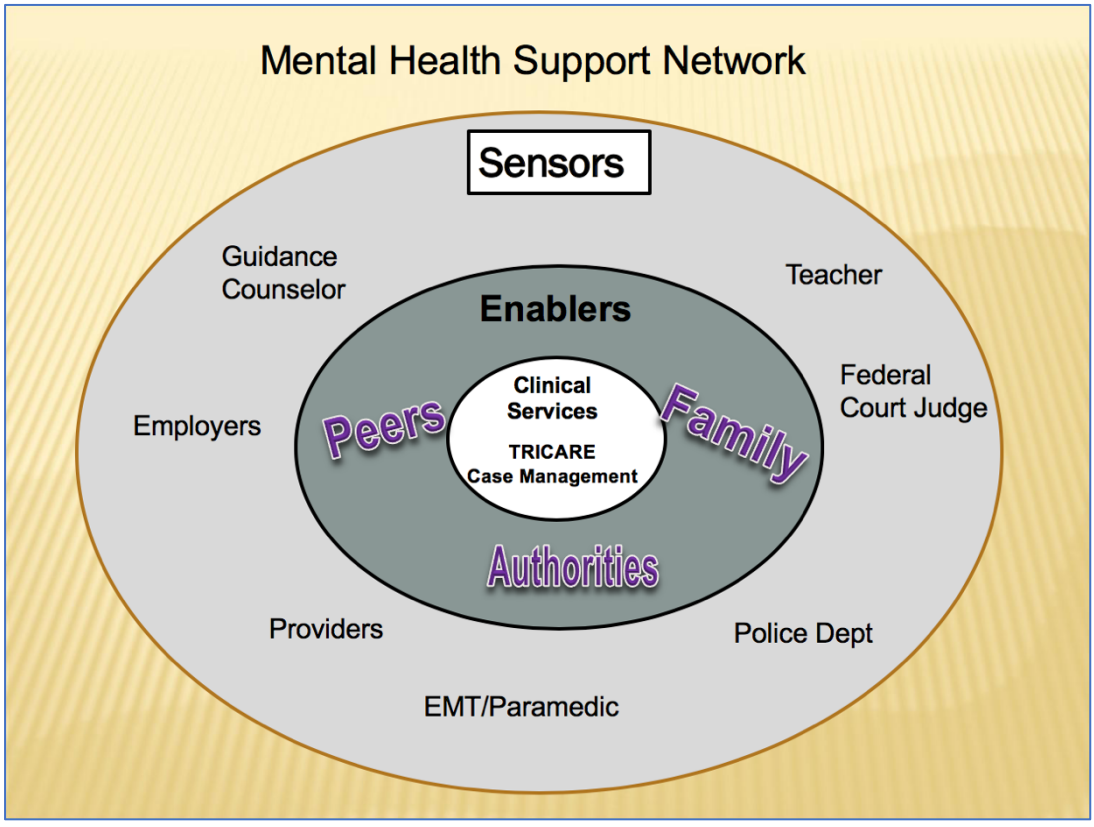
IPC RESILIENCE-ORIENTED SYSTEM OF MENTAL HEALTH CARE DIAGRAM[97]



[97] Primary document

APPENDIX G

IPC TOUCH POINTS FOR MENTAL HEALTH SUPPORT NETWORK[98]



[98] Primary document

APPENDIX H

PUBLIC HEALTH MODEL OF MENTAL HEALTH[99]

[99] Primary document

APPENDIX I

BLUE BUTTON CONNECTOR WEBSITE NOTICE

APPENDIX J

TABLE 1: MAKE THE CONNECTION CATEGORIES

Life Events and Experiences	
Death of family and friends	Family and relationships
Financial and legal issues	Retirement and ageing
Homelessness	Spirituality
Jobs and employment	Student veterans/higher education
Physical injury	Transitioning from service
Preparing for deployment	
Signs and Symptoms	
Alcohol or drug problems	Guilt
Anger and irritability	Loss of interest of pleasure
Chronic pain	Nightmares
Confusion	Noise or light irritation
Difficulty concentrating	Reckless behavior
Dizziness	Relationship problems
Feeling on edge	Social withdrawal/isolation
Feeling of hopelessness	Stress and anxiety
Flashbacks	Trouble sleeping
Gambling	
Conditions	
Adjustment disorder	Problems with alcohol

Anxiety disorder	Problems with drugs
Bipolar	PTSD
Effects of military sexual trauma	Schizophrenia
Effects of traumatic brain injury	Suicide

APPENDIX K

TIMELINE OF SCANDALS AT VA[100]

1921 -- Congress creates the Veterans Bureau to administer assistance to World War I veterans. It quickly devolves into corruption, and is abolished nine years later under a cloud of scandal.

1930 -- The Veterans Administration is established to replace the troubled Veterans Bureau and two other agencies involved in veterans' care.

1932 -- Thousands of World War I veterans and their families march on Washington to demand payment of promised war bonuses. In an embarrassing spectacle, federal troops forcibly remove veterans who refuse to end their protest.

1945 -- President Harry Truman accepts the resignation of VA Administrator Frank Hines after a series of news reports detailing shoddy care in VA-run hospitals, according to a 2010 history produced by the Independent Institute.

1946 -- The American Legion leads the charge seeking the ouster of VA Administrator Gen. Omar Bradley, citing an ongoing lack of facilities, troubles faced by hundreds of thousands of veterans in getting services and a proposal to limit access to services for some combat veterans, according to the 2010 history.

1947 -- A government commission on reforming government uncovers enormous waste, duplication and inadequate care in the VA system and calls for wholesale changes in the agency's structure.

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[100] Adapted from Pearson 2014

1955 -- A second government reform commission again finds widespread instances of waste and poor care in the VA system, according to the Independent Institute.

1970s -- Veterans grow increasingly frustrated with the VA for failing to better fund treatment and assistance programs, and later to recognize exposure to the herbicide Agent Orange by troops in Vietnam as the cause for numerous medical problems among veterans.

1972 -- Vietnam veteran Ron Kovic, the subject of the book and movie, "Born on the Fourth of July," interrupts Richard Nixon's GOP presidential nomination acceptance speech, saying, according to his biography, "I'm a Vietnam veteran. I gave America my all, and the leaders of this government threw me and others away to rot in their VA hospitals."

1974 -- Kovic leads a 19-day hunger strike at a federal building in Los Angeles to protest poor treatment of veterans in VA hospitals. He and fellow veterans demand to meet with VA Director Donald Johnson. The embattled director eventually flies to California to meet with the activists, but leaves after they reject his demand to meet in the VA's office in the building, according to Johnson's 1999 Los Angeles Times obituary. The ensuing uproar results in widespread criticism of Johnson. A few weeks later, Johnson resigns after President Richard Nixon announces an investigation into VA operations.

1976 -- A General Accounting Office investigation into Denver's VA hospital finds numerous shortcomings in patient care, including veterans whose surgical dressings are rarely changed. The GAO also looked at the New Orleans VA hospital, and found ever-increasing patient loads were contributing to a decline in the quality of care there, as well.

1981 -- Veterans camp out in front of the Wadsworth Veterans Medical Center in Los Angeles after the suicide of a former Marine who had rammed the hospital's lobby with his Jeep and fired shots into the wall after claiming the VA had failed to attend to his service-related disabilities, the New York Times reported at the time.

1982 -- Controversial VA director Robert Nimmo, who once described symptoms of exposure to the herbicide Agent Orange during the Vietnam war as little more than "teenage acne," resigns under pressure from veteran's groups. Nimmo was criticized for wasteful spending, including use of a chauffeured car and an expensive office redecorating project, according to a 1983 GAO investigation. The same year, the agency issues a report supporting veterans' claims that the VA had failed to provide them with enough information and assistance about Agent Orange exposure.

1984 -- Congressional investigators find evidence that VA officials had diverted or refused to spend more than $40 million that Congress approved to help Vietnam veterans with readjustment problems, the Washington Post reports at the time.

1986 -- The VA's Inspector General's office finds 93 physicians working for the agency have sanctions against their medical licenses, including suspensions and revocations, according to a 1988 GAO report.

1989 -- President Ronald Reagan signs legislation elevating the Veterans Administration to Cabinet status, creating the Department of Veterans Affairs.

1991 -- The Chicago Tribune reports that doctors at the VA's North Chicago hospital sometimes ignored test results, failed to treat patients in a timely manner and conducted unnecessary surgery. The agency later takes responsibility for the deaths of eight patients, leading to the suspension of most surgery at the center, the newspaper reported.

1993 -- VA Deputy Undersecretary of Benefits R.J. Vogel testifies to Congress that a growing backlog of appeals from veterans denied benefits is due to a federal court established in 1988 to oversee the claims process, the Washington Post reports. The VA, Vogel tells the lawmakers, is "reeling under this judicial review thing."

1999 -- Lawmakers open an investigation into widespread problems with clinical research procedures at the VA West Los Angeles Healthcare Center. The investigation followed years of problems at the hospital, including ethical violations by hospital researchers that included failing to get consent from some patients before conducting research involving them, according to the Los Angeles Times.

2000 -- The GAO finds "substantial problems" with the VA's handling of research trials involving human subjects.

2001 -- Despite a 1995 goal to reduce waiting times for primary care and specialty appointments to less than 30 days, the GAO finds that veterans still often wait more than two months for appointments.

2003 -- A commission appointed by President George W. Bush reports that as of January 2003, some 236,000 veterans had been waiting six months or more for initial or follow-up visits, "a clear indication," the commission said, "of lack of sufficient capacity or, at a minimum, a lack of adequate resources to provide the required care."

2005 -- An anonymous tip leads to revelations of "significant problems with the quality of care" for surgical patients at the VA's Salisbury, North Carolina, hospital, according to congressional testimony. One veteran who sought treatment for a toenail injury died of heart failure after doctors failed to take account of his enlarged heart, according to testimony.

2006 -- Sensitive records containing the names, Social Security numbers and birth dates of 26.5 million veterans are stolen from the home of a VA employee who did not have authority to take the materials. VA officials think the incident was a random burglary and not a targeted theft.

2007 -- Outrage erupts after documents released to CNN show some senior VA officials received bonuses of up to $33,000 despite a backlog of hundreds of thousands of benefits cases and an internal review that found numerous problems, some of them critical, at VA facilities across the nation.

2009 -- The VA discloses that than 10,000 veterans who underwent colonoscopies in Tennessee, Georgia and Florida were exposed to potential viral infections due to poorly disinfected equipment. Thirty-seven tested positive for two forms of hepatitis and six tested positive for HIV. VA Director Eric Shinseki initiates disciplinary actions and requires hospital directors to provide written verification of compliance with VA operating procedures. The head of the Miami VA hospital is removed as a result, the Miami Herald reports.

2011 -- Nine Ohio veterans test positive for hepatitis after routine dental work at a VA clinic in Dayton, Ohio. A dentist at the VA medical center there acknowledged not washing his hands or even changing gloves between patients for 18 years.

2011 -- An outbreak of Legionnaires' Disease begins at the VA hospital in Oakland, Pennsylvania, according to the Pittsburgh Tribune-Review. At least five veterans die of the disease over the next two years. In 2013, the newspaper discloses VA records showed evidence of widespread contamination of the facility dating back to 2007.

2012 -- The VA finds that the graves of at least 120 veterans in agency-run cemeteries are misidentified. The audit comes in the wake of a scandal at the Army's Arlington National Cemetery involving unmarked graves and incorrectly placed burials.

2013 -- The former director of Veteran Affairs facilities in Ohio, William Montague, is indicted on charges he took bribes and kickbacks to steer VA contracts to a company that does business with the agency nationwide.

2014 – VA Secretary Eric Shinseki resigns due to the fallout for the wait time scandal.

APPENDIX L

TIMELINE OF VA RESEARCH ACCOMPLISHMENTS[101]

1925 – Conducted the first hospital-based medical studies to be formally considered part of VA's newly established research program.

1**928** – Reported findings from early VA studies looking at treatments for malaria, the long-term health effects of chemical warfare, and hospitalization and mortality among veterans with mental illness.

1932 – Published data comparing outcomes at VA clinics with those at other hospitals. The VA facilities compared favorably.

1935 – Published a series of articles in the *New England Journal of Medicine* about heart disease among veterans.

1941 – Established a research lab at the Northport (N.Y.) VA medical center to conduct clinical and biomedical research in neuropsychiatric disorders; contribute to the nationwide standardization of diagnostic and treatment methods; and teach the latest concepts and methods in neurology, psychiatry, and neuropathology to VA doctors.

1946 – Established the standard for developing better-fitting, lighter artificial limbs through studies of human locomotion, enhanced surgical techniques and modernized design and manufacturing methods.

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[101] Adapted from: https://www.research.va.gov/about/history.cfm. Accessed February 1, 2019.

1947 – Developed and tested effective therapies for tuberculosis following World War II. Multi-center clinical trials led to development of the Cooperative Studies Program, which has since produced effective treatments for diseases and conditions including schizophrenia, diabetes, depression, heart disease and stroke.

1948 – Introduced VA's first mobility and orientation rehabilitation-training program for blind veterans.

1956 – Conducted groundbreaking work with radioisotopes that led to the development of modern radioimmunoassay diagnostic techniques.

1960 – Invented the first clinically successful implantable cardiac pacemaker, helping many patients prevent potentially life-threatening complications from irregular heartbeats.

1961 – Pioneered the concepts that led to development of computerized axial tomography (CAT scan).

1963 –Lasker Award given to Dr. Michael E. DeBakey for originating new techniques in cardiovascular surgery.

1967 – Performed the first successful liver transplants and developed techniques for suppressing the body's natural attempt to reject transplanted tissue.

1969 – Expanded understanding of how brain hormones interact with the endocrine system.

1970 – Published the results of a landmark VA Cooperative Study on hypertension, showing that drug treatment was effective in controlling blood pressure and reducing the incidence of major cardiovascular events.

1971– Lasker Award given to Dr. Edward Freis for developing drug therapy for moderate hypertension.

1974 – Lasker Award given to Dr. Ludwig Gross for discovering leukemia- and cancer-causing viruses.

1975 – Lasker Award given to Dr. William Oldendorf for pioneering the concept of computerized tomography.

1976 – Lasker Award given to Dr. Rosalyn Yalow for developing the diagnostic technique of radioimmunoassay.

1977 – Nobel Prize awarded to VA researchers Dr. Andrew Schally, for his research on peptide hormone production in the brain; and Dr. Rosalyn Yalow, for her development of radioimmunoassay to detect and measure various substances in the blood.

1984 – Developed the nicotine patch and other therapies to help smokers quit.

1989 – Discovered a peptide in venom from the Gila monster, a type of lizard, that would eventually serve as the basis for a widely used diabetes drug.

1991 – Established the Cleveland Functional Electrical Stimulation (FES) Center, which focuses on the application of electrical currents to either generate or suppress activity in the nervous system.

1993 – Developed and tested a new device that has led to improved wheelchair designs by enhancing assessments of upper extremity pain in manual wheelchair users.

1994 – Demonstrated that one aspirin tablet a day reduced by half the rate of death and nonfatal heart attacks in patients with unstable angina.

1995 – Conducted the National Surgical Quality Improvement Program, which is instrumental in identifying ways to improve surgical care.

1996 – Identified the gene that causes Werner syndrome, a disease marked by premature aging.

1997 – Identified a gene associated with a major risk for schizophrenia.

1998 –Nobel Prize awarded to researcher Dr. Ferid Murad (who had been at Palo Alto VA 1981-1986) for his discoveries relating to nitric oxide, a body chemical that helps maintain healthy blood vessels.

1999 –Launched the first treatment trials for Gulf War Veterans' Illnesses, focusing on antibiotics and exercise.

2000 – Showed that colonoscopy is superior to the more widely used sigmoidoscopy as a primary screening mechanism for colon cancer.

2001– Began the first clinical trial under the Tri-National Research Initiative, with researchers from VA collaborating with colleagues from Canada and the United Kingdom to determine the optimal antiretroviral therapy for HIV.

2002 –Published, together with National Institutes of Health colleagues, the main results from the landmark ALLHAT study, the largest hypertension study ever, which found that conventional diuretics were better than newer medicines for treating high blood pressure.

2003 – Created a national registry of veterans with Lou Gehrig's disease (ALS) to track the health status of Veterans with the disease and help recruit research participants.

2004 – Showed that the antioxidant lutein could not only help prevent macular degeneration, but also reverse symptoms.

2005 –Showed the effectiveness of a new vaccine for shingles, a painful skin and nerve infection that affects older adults.

2006 – Established the Center for Imaging of Neurodegenerative Diseases at the San Francisco VA, in collaboration with the Department of Defense.

2007 – Unveiled the first powered ankle-foot prosthesis, developed in collaboration with researchers at MIT and brown university.

2008 – Results of one of the first randomized clinical trials comparing different treatment approaches for those with traumatic brain injury.

2009 – Showed that the traditional "on pump" method of heart bypass surgery yields better outcomes after one year than "off pump" surgery, which does not use a heart-lung machine.

2010 – Collaborated with the Department of Defense and National Institutes of Health on publishing "common data elements" to speed progress on research focused on traumatic brain injury and posttraumatic stress disorder.

2011 – Launched the Million Veteran Program, which will establish one of the world's largest databases of health and genetic information, for use in future research aimed at preventing and treating illness among Veterans and all Americans.

2012 – Published results from a major study of abdominal aortic aneurysms that provided valuable guidance on surgical treatment options.

2013 – Announced the formation of new research consortia, funded jointly by VA and the Department of Defense, to study PTSD and traumatic brain injury.

2014 – Reported on new prosthetics technology to help restore the sense of touch for those who have lost an upper limb and use an artificial hand.

2015 – Invented a wheelchair that allows users to crank up the push rims to a standing position, providing them with increased functionality and independence.

2016 – VA had enrolled 500,000 veterans in the Million Veteran Program – an initiative that aims to build the world’s largest genomic database